

**A Qualitative Exploration of Children's Understanding of  
Indiscriminate Friendliness**

AND RESEARCH PORTFOLIO

Part I

(Part II bound separately)

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## CHAPTER 1: AUDIT PROJECT – MANAGEMENT REPORT

What characterises the asylum seekers accessing clinical psychology services and the treatment they receive within the south sector of Glasgow?

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Background: There is a perception that asylum seekers accessing clinical psychology services consume a greater amount of resources than patients from the indigenous population. This was a view held within the Clinical Psychology department in the south of Glasgow. However, there was no objective understanding of the way in which asylum seekers engage in the service. Therefore, an audit of all asylum seekers accessing the specified service within a 12 month timeframe was carried out. Method: Asylum seekers accessing the service within the specified timeframe were identified by Clinical Psychologists, referral lists and through a Glasgow-wide database of asylum seekers accessing mental health services. Information on demographic profile, reason for referral, treatment received, discharge and workload outside of treatment sessions was gained from casenotes. Results: Thirty-nine asylum seekers accessed clinical psychology services within the specified timeframe. Referrals were typically male, aged 30-39 years and related to sleep difficulties, depression, anxiety and PTSD symptoms. Links to torture and trauma were also common. Patients were typically in treatment for six months and attended eight sessions. Discharge was most commonly due to non-attendance or completion of treatment. A small number of reports, phone calls and letters other than those to GPs were documented in relation to work with asylum seekers. Discussion: An objective description of the treatment accessed by asylum seekers was gained which demonstrated a degree of heterogeneity but offered a picture of the typical presentation and average use of the Clinical Psychology service. This had implications for clinical practice and suggested that more thorough recording of work outside of treatment sessions may be beneficial. Comparison to treatment of indigenous populations recommended.

Asylum seekers leave their country of origin and are unable or unwilling to avail themselves of the protection of that country because of a well-founded fear of persecution, for reasons of race, religion, nationality, membership of a particular social group or political opinion (United Nations Convention, 1951). Official figures state there were 5,798 asylum seekers registered in Glasgow in January 2005 (CoSLA Refugee and Asylum Seekers Consortium, 2005).

Consultation with Clinical Psychologists within the south of Glasgow revealed a perception that a lot of their time was consumed by work with asylum seekers. Indeed, Burnett and Peel (2001) comment that health workers can sometimes feel overwhelmed by the many and varying needs of asylum seekers. They state that this is especially the case as many of these needs are often non-medical but these have clear psychological and physical health consequences. While this perception is not novel (Clark, 2004; Drummond, 2003) an objective assessment of the way in which asylum seekers make use of clinical psychology services in the studied geographical area was required.

High levels of both physical and mental health problems have been found among asylum seekers in comparison to the indigenous population (King's Fund, 2000). Mental health difficulties commonly identified among asylum seekers include anxiety, depression, panic attacks, agoraphobia, trauma related symptoms and sleep difficulties (Brent & Harrow Health Authority, 1995). Prevalence estimates are unclear, but there is a suggestion that 60% of asylum seekers have mental health difficulties (Conelly & Schweiger, 2000), with depression and post traumatic stress disorder being the most common of these (deJong et al, 2000). Such symptoms are

often linked with both past experiences and current circumstances surrounding asylum status (Acheson, 1998).

Experience of trauma, such as torture, has been associated with subsequent mental health problems (Burnett & Peel, 2001). Montgomery and Foldsprang (1994) and Eisenman, Keller and Kim (2000) estimate that 5-30% of asylum seekers have experienced torture. The United Nations consider any acts inflicting intentional pain or suffering for purposes of punishment, gaining information, intimidation, coercion, or resulting from an official acting in an official capacity as acts of torture. These are often associated with political motives. Experience of trauma, mental health difficulties and the minority status of asylum seekers makes this patient group eligible for special help in gaining access to mental health services according to the National Service Framework for Mental Health (Department of Health, 1999). This emphasises that special help is needed for such excluded groups. Gorst-Unsworth, Shackman and Summerfield (1996) suggest that symptoms requiring such specialist help may include consistent failure to function properly, frequent suicidal ideation, marked social withdrawal, self neglect, behaviour or talk seen as abnormal or strange within a person's own culture along with aggression towards others.

This audit aimed to provide descriptive data on a number of factors involved in the clinical psychology services accessed by asylum seekers within south Glasgow in order to objectively assess the actual workload. The study aimed to explore the following areas:

1. The number of asylum seekers accessing the service
2. The demographic profile of asylum seekers accessing the service

3. The reasons for referral to the service
4. The duration and attendance of clinical psychology treatment being accessed
5. The number of patients requiring interpreters and number of sessions being cancelled due to unavailability of interpreters
6. The reasons for discharge of asylum seekers who accessed the service
7. Clinical Psychologist workload outside of treatment sessions in relation to work with asylum seeker patients

These data were collected from case files of all asylum seekers accessing clinical psychology services in the south of Glasgow between 1<sup>st</sup> July 2003 and 30<sup>th</sup> June 2004.

## METHOD

### Design

A retrospective descriptive analysis of the referrals and treatment received by all asylum seekers accessing clinical psychology services within the south of Glasgow between 1<sup>st</sup> July 2003 and 30<sup>th</sup> June 2004.

### Participants

The term asylum seeker refers to a person who seeks protection under the Convention of Refugees after ending another country on a temporary visa or without documents (Silvoe, Steel & Watters, 2000). Individuals taking part in this study were at different parts of the asylum process; some at their first application, some



appealing a decision, some had been granted asylum and some had recently had their asylum claim rejected.

Asylum seekers who had contact with the south Glasgow clinical psychology services between 1<sup>st</sup> July 2003 and 30<sup>th</sup> June 2004 were identified through three methods; i) consultation with all Clinical Psychologists within the service, ii) screening clinical psychology referral lists for individuals who may be asylum seekers, and, iii) accessing patient information from the Compass<sup>1</sup> database which holds first contact information on all asylum seekers accessing mental health services within Glasgow. Permission to access the Compass database was granted by the head of service, Dr Anne Douglas.

This process identified 74 patients who may have been asylum seekers who accessed clinical psychology services within the specified timeframe. Thirty-nine were included in the audit sample while 35 were rejected as they did not meet the timeframe criteria, were treated by Community Psychiatric Nurses instead of psychologists, were not asylum seekers or their files were not traceable. Demographics of this sample are provided in detail within the results section

## Materials

A data collection sheet was developed following reference to relevant literature and consultation with Consultant Clinical Psychologists within the service. The sheet provided a structure for gaining information on demographics, reason for referral,

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<sup>1</sup> Compass is a specialist multidisciplinary mental health team offering psychosocial interventions for trauma and torture to asylum seekers within Glasgow.

treatment received, contacts made by psychologists in relation to the patient and onwards referral (see appendix 1.1).

### Procedure

All Clinical Psychologists were requested to provide the names of all relevant patients from the target timeframe. In addition, names of asylum seekers identified in the Compass database following engagement in south Glasgow Clinical Psychology services were also acquired. Case files of these patients were accessed and the relevant data collected on each if the criteria of psychological treatment in the south Glasgow service within the stated timeframe were met.

Finally, a screening of the names of individuals referred to the service was carried out to double check that relevant patients had not been overlooked through the previous two methods of patient identification. This may have been possible if tracker forms had not been sent to Compass due to an oversight or if the psychologist was not the first mental health contact. In addition, the patients may have been seen by a psychologist who had left the service. The use of triangulation attempted to ensure all relevant patients were identified.

Referral and demographic information was gained from referral letters. Where referral letters were not included in casenotes this information had to be gained from letters written by Clinical Psychologists. Treatment, contact and onward referral information was gained from psychology notes and also from letters and reports written by psychologists. Data collection for each patient took an average of 15 minutes.

## RESULTS

### *1 Number of asylum seekers accessing the service*

Thirty-nine asylum seekers were identified as accessing clinical psychology services between 1<sup>st</sup> July 2003 and 30<sup>th</sup> June 2004.

### *2 Demographic profile of asylum seekers accessing the service*

#### 2.1 General Demographics

The majority of the sample were male (N = 23, 59.0%; Female N= 16, 41.0%) and were aged 20 to 39 years (N=29, 74.36%). Figure 1.1 illustrates the age distribution of the sample using five year age bands. This identifies the mode age band as 30 to 34 years. It should be noted that there were few referrals older than 40 years and younger than 20 years.

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Insert figure 1.1 about here

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#### 2.2 Country of origin, first language and asylum status

The majority of asylum seekers originated from Turkey (N=12, 30.8%), five (12.8%) originated from Iran, three (7.7%) originated from Kosovo, Afghanistan and Algeria and two originated from the People's Republic of the Congo (5.1%). In addition, one (2.6%) originated from each of the following countries; Azerbaijan, Serbia, Sri Lanka, Palestine, Kurdistan, Kenya, Iraq, Russia and Burundi. Country of origin was not available for two asylum seekers in the sample. Information on first language

was available for 30 of the asylum seekers; 11 Turkish (28.2%), five French (12.8%), four Farsi (10.3%), four Albanian (10.3%) and Azzai, Tamil, Iranian, Kurdish, Swahili and Russian were each identified as being the first language of one (2.6%) individual. Information on first language was not provided for nine individuals as they were able to communicate in English.

### 3 Reason for referral to clinical psychology

The majority of asylum seekers were referred by GPs (N=29, 74.4%), while five (12.8%) were referred by psychiatrists, two were referred by Community Psychiatric Nurses (5.1%), one (4.3%) was referred by a psychiatrist, one by the dental hospital and another from the Compass Team. The vast majority were within the Greater Shawlands catchment area (N=19, 48.7%), eight (20.5%) within the Castlemilk area, seven (17.9%) within the Southwest area and the remaining five falling within the Gorbals area (12.8%). Twenty-seven (69.2%) of these individuals were identified as requiring an interpreter.

Figure 1.2 provides a summary of the number of times referral letters mention symptoms relating to anxiety, depression, PTSD, sleep difficulties and somatic problems. In addition, this bar chart notes the number of cases in which torture or trauma were implicated in the referral. Individual patients may be represented in more than one reason for referral.

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Insert figure 1.2 about here

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Symptoms of depression, post traumatic stress and sleep disturbances were the most common with each being included in referral letters of 25 (64.1%) patients. Depressive symptoms included low mood and tearfulness while symptoms of post traumatic stress disorder included flashbacks and nightmares. Sleep difficulties included delayed sleep onset and early morning wakening. Anxiety (N=19, 48.7%) symptoms, such as fears and phobias, was also a frequent reason for referral to clinical psychology while somatic complaints (N=11, 28.2%), especially headaches, were also notable. It is of particular note that mention of torture, trauma and politically motivated attacks were particularly common in this sample. These included abduction, beatings, electric shocks, rapes and witnessing murders. Such information was found in referral letters and clinical notes of 31 (79.5%) individuals.

#### 4 Characteristics and attendance of treatment

Time between referral and offer of an appointment had a mean time of 4.76 months (SD = 2.54 months, range = 1-11 months, mode = 6 months). Figure 1.3 illustrates total number of sessions attended for all asylum seekers in this sample. Five of the individuals in the sample did not attend any appointments and no data was available for number of sessions attended by one patient.

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Insert figure 1.3 about here

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The remaining 33 attended for a mean of 7.87 sessions (SD = 6.65, range 1-29 sessions, mode =1, 8 and 15 sessions). The distribution of total number of sessions is

interesting in three quarters of the sample attended 1 to 10 sessions ( $N=26$ , 78.79%) while there was much more variation in the remainder of the sample whose number of sessions ranged from 14 to 29 (see Figure 3).

There was also a wide range observed in the length of time engaged in treatment (1-24 months,  $M = 6.21$  months,  $SD = 5.48$  months, Mode = 2 months,  $N = 5$  never engaged in treatment,  $N = 1$  no data on length of treatment). Yet, it should be noted that half of all patients in the sample ( $N = 19$ , 57.58%) spent between one and five months in treatment while the remainder were in treatment for a greater variety in length (six to 29 months).

Non-attendance (DNAs) accounted for only 31 sessions, which included six sessions by patients who did not engage in treatment at all. There was a mean of 0.84 DNAs ( $SD = 0.96$ ). Seventeen sessions were cancelled by patients ( $M = 0.46$ ,  $SD = 0.99$ ).

Two of the 23 men (5.1%) also attended the men's asylum seeker group at Compass and four of the 16 women (10.3%) attended the equivalent women's group during treatment.

## 5 Use of interpreters

Case notes indicated that interpreters were used in the treatment of 24 patients and that a total of 11 sessions were spoiled due to non-attendance or late attendance of an interpreter ( $M = 0.72$ ,  $SD = 1.93$ ).

## 6 Reasons for discharge

There were six reasons given for the ending of treatment within this sample. Five (12.8%) patients were discharged as they did not take up the offer of an appointment and another 15 (38.5%) were discharged as they failed to attend appointments after becoming engaged in treatment. Nine (23.1%) were discharged upon completion of treatment, four (10.3%) finished treatment early as the Clinical Psychologist was leaving their post, two (5.1%) moved to another catchment area and another two (5.1%) patients decided to end treatment. A final patient (2.6%) was discharged as they were unable to engage in treatment. Four (10.3%) patients were still in treatment at the time of data collection.

Six of the discharged patients were referred elsewhere by their Clinical Psychologist on completion of treatment. One was referred to a Community Mental Health Team, two to the Compass women's asylum seeker group, one to both housing services and the Ethnic Minority Law Centre, one to another psychologist for follow-up and one to the Scottish Refugee Council.

## 7 Clinical workload outside of treatment sessions

Table 1.1 summarises the workload over and above session time which was documented for this sample. This illustrates that while virtually all patients required GP letters, only 28.21% required additional letters, 36.36% necessitated phone calls and 15.40% required reports to be written. Reports were typically summaries of assessment and treatment in support of asylum applications.

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Insert table 1.1 about here

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These contacts were conducted with a number of other professionals. Thirteen Clinical Psychologists contacted other health professionals, five were in contact with housing services, five were in contact with solicitors, three with Asylum Support Services, another with the Ethnic Law Group and one contacted the Compass team in relation to their asylum seeker patients during treatment. Further, one Clinical Psychologist attended an Asylum Appeal.



**Referral summary**

Referrals tended to come from GPs within the Greater Shawlands area, included symptoms of depression, sleep disturbance, PTSD and anxiety. Three quarters of the sample reported experience of torture or politically motivated trauma.

**Demographic and nationality profile summary**

The typical asylum seeker referred to south clinical psychology services in the specified timeframe was male, aged 30-34 years, originated from Turkey and had Turkish as their first language.

**Treatment summary**

The typical patient waited five months for an appointment, they attended seven sessions, were in treatment for six months and used an interpreter. Non-attendance at sessions was the most common reason for discharge followed by completion of treatment. Women were more likely than men to attend a group concurrently to receiving psychological treatment.

## DISCUSSION

This audit aimed to provide descriptive data on a number of factors involved in the Clinical Psychology services accessed by asylum seekers within south Glasgow in order to objectively assess the actual workload.

Thirty-nine asylum seekers accessed clinical psychology within south Glasgow during the 12-month timeframe examined. While an awareness of the diversity amongst asylum seekers is important, an understanding of the typical asylum seekers presenting to south Glasgow Clinical Psychology services may help to alleviate anxieties about treating this group of patients (Clark, 2004). The typical asylum seeker accessing clinical psychology service was aged 30-34 years, male, originated from Turkey, spoke Turkish as a first language and had experienced trauma or torture.

This group of patients were predominantly referred by their GP and presented with symptoms of depression, sleep difficulties, PTSD and anxiety. Mention of trauma of torture was typically included in referrals. An appointment was offered within five months, patients attended eight sessions, were in treatment for six months and had good attendance. Women were more likely to attend support groups for asylum seekers concurrently to psychological treatment in comparison to men.

The majority of patients in this sample required an interpreter to access the service and there were very few sessions cancelled due to problems with interpreter provision. Discharge was typically due to treatment completion or non-attendance

following engagement in treatment. Few patients were referred elsewhere following treatment.

Two GP letters constituted the average workload in addition to individual sessions. Approximately thirty per cent of the sample required additional letters and phone calls to be made while approximately fifteen per cent required reports and face-to-face contacts with other agencies. The psychologist workload is lower than that reported by Drummond (2003) who audited asylum seekers' use of clinical psychology services within the north of Glasgow during 2002. However, the mean number of appointments attended was similar as was the number of referrals. Any differences in work outside sessions between the two data sets were not greater than one. This may indicate that there is a degree of uniformity in workload experience by clinical psychology services across Glasgow specific to the care of asylum seekers.

While there is a belief that the basic needs of asylum seekers overwhelm psychologists (Burnett & Peel, 2001; Clark, 2004) this was not evidenced by the workload documented in casenotes. However, there is a possibility that all phone calls and face-to-face contacts relating to asylum seeker patients are not being documented by Clinical Psychologists. If this is the case, it may be wise for psychologists to log such work in case notes as this will evidence any increased workload implicated in working with asylum seekers. This could then support any request for additional resources to be allocated to areas with high referral rates of this special population (Clark, 2004; Murphy, Ndegwa, Rojas-Jaimes & Webster, 2002).

Speaking to psychologists reveals that there is a clear emotional component of working with asylum seekers. This suggests that this group of patients do necessitate additional work to that of working with patients from the indigenous population. However, the lack of evidence of high workload outside of session time may indicate that the basic needs (i.e. physiological needs such as food and safety needs such as freedom from fear, Maslow, 1954) of asylum seekers are being met elsewhere. Certainly, there is a need for these to be met prior to trauma exposure work being undertaken (Murphy, Ndegwa, Rojas-Jaimes & Webster, 2002) to ensure patients feel stable and secure. Also, it should be noted that the practical interventions of reducing isolation, gaining suitable accommodation, accessing education and employment have been found to relieve anxiety and depression (Shackman & Reynolds, 1996).

Thoroughness of record keeping of psychologists and method of identifying asylum seeker patients were the problematic issues of this audit. Firstly, data collected was dependent upon accurate recording of treatment sessions, non-attendance, cancellations and additional workload. Therefore, this audit can only claim to be an accurate representation of this practice as opposed to representative of actual clinical practice with this client group. Secondly, while attempts were made to identify all asylum seekers accessing the service within the stated timeframe there is a possibility that some may have been overlooked as there was no systematic method of identifying these patients. For future reference it may be prudent to further encourage staff to send tracer forms of asylum seekers accessing psychology for inclusion in the Compass database and it may also be prudent to keep a database of

asylum seekers accessing south psychology services within the south clinical psychology department itself.

While practical constraints were apparent, the study was able to objectively gain the data required to address the target areas for exploration outlined in the introduction. In this way the audit has provided an objective assessment of the workload of treating asylum seekers within the south sector of Glasgow by clinical psychologists. While such an objective view is useful in itself it would be beneficial to take this a step further and to audit treatment of the indigenous population within this service in order to make contrasts between the two populations. The lack of information to make such a contrast could be considered a failing of this piece of work.

Further research is required to assess whether specific factors related to asylum status suggest a need for longer treatment with some asylum seekers for trauma work. Assessment of whether basic needs of the asylum seeker have been met could be used as an indicator as to whether basic anxiety management or deeper interventions are more relevant. This distinction would be worthy of further research.

Using the data described there does not appear to be a great pressure put upon the service, however it should be noted that nearly half of these patients were treated by a single psychologist due to concentration in a particular catchment area. Thus, it could be suggested that asylum seeker referrals could be spread more evenly across the department as such high contact with traumatised individuals can be draining for any clinician (Clark, 2004).

On a more positive note, the number of cases being discharged due to treatment completion could be taken as an indication that short-term interventions used with the indigenous population are equally effective with asylum seekers.

To summarise, this audit has provided an objective assessment of the burden of treating asylum seekers upon Clinical Psychology services within the south of Glasgow. Thirty-four asylum seekers accessed the service within a 12 month period who placed a relatively low demand upon the service as a whole. However, the concentration of asylum seekers within one area of Glasgow resulted in a high number of referrals being imposed upon one Clinical Psychologist. This may account for the sense of being overwhelmed which has been reported within the department. Suggestions of further research and service provision have been made.

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Figure 1.1 Bar chart displaying age bands of patients at referral to clinical psychology service

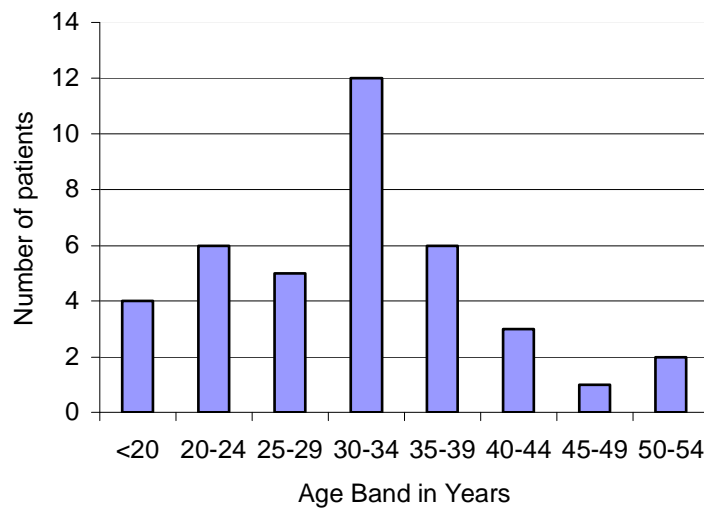


Figure 1.2 Bar chart displaying the most common referral symptoms

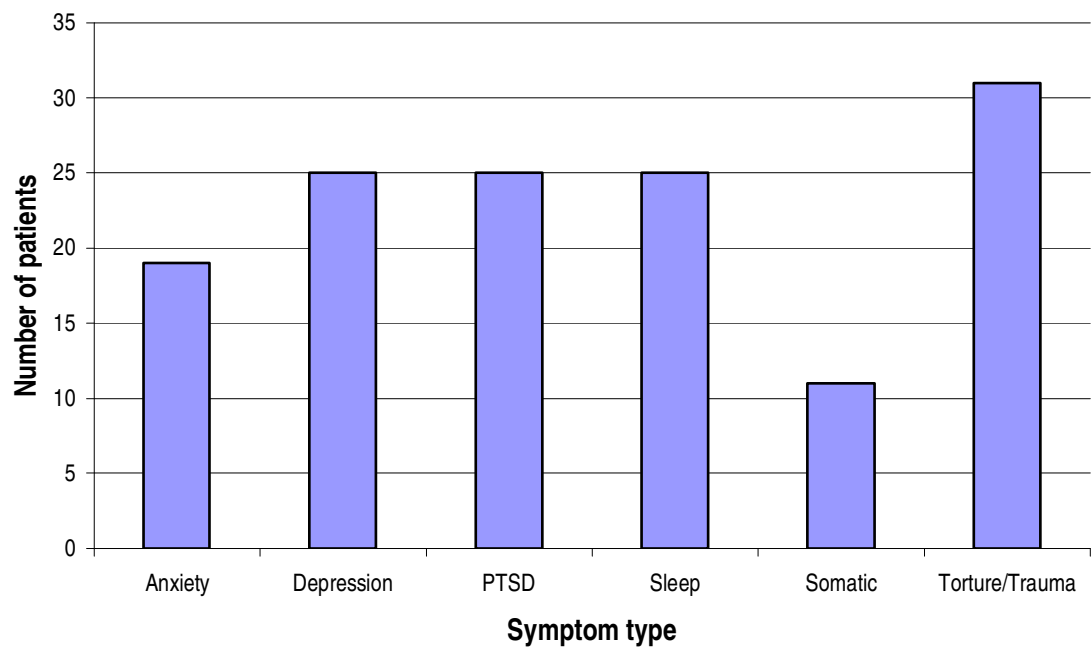


Figure 1.3 Bar graph displaying total number of clinical psychology sessions attended by each patient

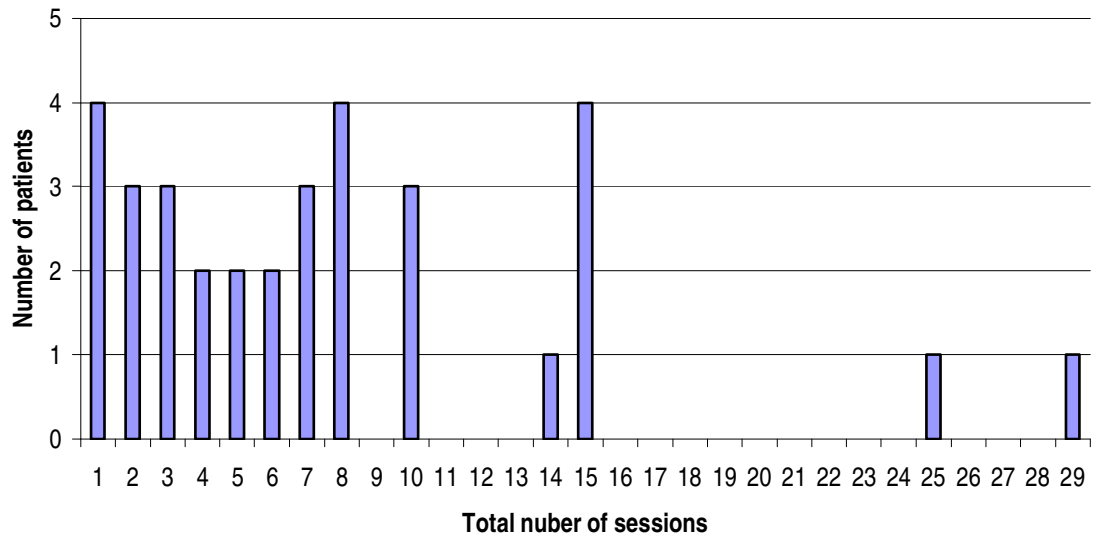


Table 1.1 Mean, standard deviation and range of variable contributing to workload

Type of communication	Mean (SD)	Range	Number of patients (%)	Total number of communications of each type
GP letter	1.87 (0.93)	1-5	39 (100.00)	71
Other letters	0.37 (0.63)	0-2	11 (28.21)	14
Reports	0.16 (0.37)	0-1	6 (15.40)	6
Phone calls	0.74 (1.41)	0-7	12 (36.36)	28
Face-to-face	0.13 (0.34)	0-1	5 (12.80)	5

## CHAPTER TWO: SYSTEMATIC REVIEW

The impact of childhood maltreatment upon children's social competence  
in interactions with peers - a systematic review.

Prepared in accordance with the guidelines for Child Development (Appendix 2.1)

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## Abstract

A lack of consistency in definition and assessment of social competence has made it difficult to compare results across studies of maltreated children and to translate findings into clinical interventions. This systematic review assessed the methods employed to assess maltreated children's social competence in their peer interactions. Twenty papers were reviewed according to quality criteria developed in reference to social competence literature. Social competence remains a poorly operationalized concept without reference to the global-specific scale which it encompasses. However, the growing use of peer and multiple raters, the use of ecologically valid contexts, more detailed examinations of social competence and standardised measures of maltreatment have improved the quality of research.

**Keywords:** systematic review, maltreatment, social competence, children

This review systematically evaluates the methodology employed in research assessing the social competence of maltreated children. Several reviews of maltreatment sequelae have been published (Cicchetti & Toth, 1995, Conaway & Hansen, 1989; Lamphear, 1985; Malinosky-Rummell & Hansen, 1993). While some of these have examined social competence outcomes for maltreated children this has typically been within a review of numerous psychosocial outcomes. The concept of social competence is defined, followed by an overview of social outcomes for maltreated children and the methodological difficulties inherent in maltreatment research to provide the background for the review of target literature.

### *Social competence*

There were as many definitions of social competence as there are researchers in the field Dodge (1985). This has led to a lack of clarity in the meaning ascribed to social competence across studies due to different assessment formats. Nevertheless, Cavell (1990) writes that researchers tend to agree that social competence is defined as effective functioning within social contexts. Authors continue to omit definitions of social competence and use numerous measures to assess this. Cavell (1990) notes that these measures all assess social competence, albeit through different routes. Products of social functioning are typically used to assess social competence in consideration of global judgements and peer acceptance via observation, peer nominations, self-report, teacher or parent-report ratings.

Dirks, Treat and Weersing (2007) state the importance of considering of child, behaviour, situation and judge factors in the assessment of social competence. McFall's (1982) defined social competence as being "somebody's judgment that a person's

behaviour in a given situation was effective” (p. 13) this includes all of these factors. Cavell (1990) placed less emphasis on the judge in defining social competence as “the degree to which an individual’s responses to relevant, primarily social situations, meet socially valid criterion” (p.118).

While social competence measures typically generate global statements these often originate from different view points, e.g. peer or teacher, and are derived from experience of the child in different environments, e.g. summer camp or classroom. While some measures pinpoint particular behaviours, such as approaching a peer, sharing or social problem solving, the majority offer a global perspective on effectiveness of the child’s interactions. Such measures have the ability to identify children who have difficulties in social interaction (Cavell, 1990) but these may not be sufficiently detailed to indicate areas of skill with which any particular child may require assistance (Dirk et al., 2007).

#### *Social Competence among maltreated children: Previous reviews*

Conaway and Hansen (1989) reviewed literature on the social behaviour of physically abused and physically neglected children. They included six papers which were divided on their conclusions regarding social competence of maltreated children. Two studies used maternal and teacher global ratings of social competence and found no significant differences between social competence ratings while four studies found that physically abused children had significant social competence deficits compared to non-maltreated peers according to maternal ratings.

Cicchetti and Toth (1995) examined the consequences of maltreatment from a developmental perspective. They noted raised physical aggression, verbal aggression,

disruptive and avoidant interactions amongst maltreated children. Further, maltreated children were also observed to be less prosocial which place maltreated children at risk for peer rejection and isolation.

In a review of social skills training for maltreated children Howing, Wodarski, Kurtz and Gaudin (1990) referred to research stating that, even as toddlers, maltreated children socially isolate themselves and that by school age children have difficulty understanding complex social roles and others feelings and motives. There was also consistent evidence that maltreated children possess a number of risk factors within their lives irrespective of maltreatment history; low socioeconomic status, restricted educational opportunities, social isolation, conflict between parents and unstable family situations.

### *Methodological issues*

Conaway and Hansen (1989) expressed concern about the use of parental ratings for social competence of maltreated children as these parents may lack social competence themselves (Kelly, 1983; Wolfe, 1985) and have unrealistic expectations of their child's behaviour (Azar, Robinson, Hekimian & Twentyman, 1984; Bauer & Twentyman, 1985; Rosenberg & Reppuci, 1983). They also highlighted the lack of clarity in assessing maltreatment history, lack of direct observations, lack of peer-report measures and the use of a single judge. Concerns were also raised about a lack of appropriate matching of controls with maltreated peers - for example on socio-economic class and family violence, a lack of longitudinal designs and concern regarding lack of specificity on type of maltreatment experienced. Trickett and McBride-Chang (1997) reiterated these concerns in their review of maltreatment

literature. They also highlighted the importance of using standardised measures with an appreciation of validity and reliability of these tools, assessors being blind to maltreatment history, small sample sizes preventing studies reaching sufficient power to detect significant differences and consideration of vast age ranges without consideration of developmental stages.

*Why it is important to do this review?*

Many studies of the sequelae of childhood maltreatment have been published. These have been of varying quality and each study have typically analysed such a number of factors that it has been difficult to isolate social competence outcomes. Further, the varying clarity of the social competence definitions employed and the validity of the measurement of this is inconsistent. This systematic review aims to provide clarity on the concept of social competence for researchers and clinicians working with maltreated children through the following objectives:

1. To assess the construct of social competence and tools for assessing this within child maltreatment literature.
2. To systematically evaluate the methodology employed in maltreatment studies of social competence.
3. To synthesise research assessing the impact of childhood maltreatment on the social competence of children and adolescents within the context of methodological rigour.



## Method

### *Search strategy for identification of studies*

Medline, British Nursing Index, Cumulative Index to Nursing & Allied Health Literature, PSYCHINFO and EMBASE electronic databases were searched from 1990 to April 2007. Title keywords ABUSE, NEGLECT and MALTREATMENT were entered separately and summed using the OR command. Title keyword phrases SOCIAL COMPETENCE, SOCIAL SKILLS, SOCIAL ABILITIES, SOCIAL DEFICITS, RELATIONSHIPS and INTERPERSONAL were also entered separately and combined using the OR command. A third title keyword search term of CHILD was entered separately. This resulted in a group of papers with maltreatment content, social competence content and child content. Papers with a component of each search subgroup were searched using the AND command.

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Insert Figure 2.1 about here

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The process of identifying papers is illustrated in Figure 2.1. A sensitivity search was also carried out. This included screening of references from identified papers, using the ‘cited by’ function in electronic databases and targeted searches of relevant journals (‘Child Maltreatment’, ‘Child Abuse & Neglect’, ‘Developmental Psychology’ and ‘Development and Psychopathology’). Full text copies of 30 papers were considered for inclusion and 20 of these met criteria for inclusion.

### *Inclusion and Exclusion Criteria*

Titles and abstracts of identified papers were screened using inclusion and exclusion criteria. Included studies were required to be empirical, focus on maltreated children and adolescents, to include an assessment of social competence in relation to peer interaction and to have a control group. Participants had to aged 6-18yrs. Case studies, dissertations, qualitative studies, projective assessments, reviews, theoretical papers, tool development papers, those written in languages other than English or prior to 1990 were excluded. The studies reviewed were observational as this review is interested in looking at differences between two ‘naturally’ occurring groups rather than groups which can be randomly assigned or created. Therefore, randomised controlled trials are excluded from this review.

### *Methods of the review*

Results and method of each paper meeting inclusion criteria are summarised and methodological points are discussed. The quality of each paper is systematically examined using quality criteria constructed (see Appendix 2.2) following consultation of Scottish Intercollegiate Guideline Network methodology (2004) and consideration of the methodological factors reviewed above. This quality assessment compares the aims, procedure, participant factors, assessment and statistical analyses employed in the selected studies with what would be expected of a rigorous observational study.

Inter-rater reliability was assessed through comparison of overall ratings from two independent raters. Where total percentage quality ratings were within 10% of each other these were accepted as consistent. Where these varied by more than 10% the author and second rater discussed section scores differing by more than one point and

differently rated questions were negotiated until sufficient agreement could be made to ensure total quality ratings within 10% of each other.

## Results

### *Included Studies*

The search identified 392 potential papers for inclusion following keyword search (see Figure 2.1). After examination of titles and abstracts full-text was obtained for 16 papers of which 10 met the inclusion criteria. A sensitivity search examining targeting journals, author searches and examination of reference sections of accepted papers identified 10 additional papers meeting criteria following the exclusion of four papers after reading their full-text.

Papers were rejected from inclusion in this review on reading the full-text. These were excluded as they did not include a control group, did not use a measure of social competence or interaction with peers was not included. Other studies focused on internal representations and stories to assess social competence rather than judgements relating to actual peer interactions. Another paper was excluded as it only focused on one very narrowband social competence, peer rejection.

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Insert Table 2.1 and Table 2.2 about here

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Findings presented within the reviewed papers are summarised according to design and social competence assessment tools utilised. Demographic and recruitment information

for each study is supplied in Table 2.1. Maltreatment and social competence tools along with a brief methodological critique for each study is summarised within Table 2.2 .

### *Longitudinal Studies*

*Indirect assessment of social competence.* Bolger, Patterson and Kupersmidt (1998) carried out a rigorous study of peer relationships and self-esteem among maltreated children (N=214). They found difference in popularity, friendship quality, reciprocal playmates and peer conflict by both maltreatment status and subtype (see Table 2.2). Bolger and colleagues were able to detail “pathways not only into but also out of risk status” (p.1195). Their study was robust in the use of a longitudinal design, multi-raters of social competence using reliable and valid tools, and clear presentation of their multi-factor data. Unfortunately, this rigour was undermined by a lack of attention to participant opt-in and drop-out rates and a lack of appreciation of power issues. They met 55% of the criteria assessed.

An analysis of a 5-year long study of a community sample (N=585) was carried out by Dodge, Pettit and Bates, (1994) using peer, teacher and parent ratings. Social preference scores, popularity ratings and peer rejection varied by maltreatment status with these differences increasing over the duration of the study (see Table 2.2). Recruitment of maltreated and non-maltreated children from the same source, a longitudinal design, attention to opt-in and drop-out rates along with rigorous assessment lead to 66% of criteria being met. One issue with this paper was the use of two cohorts for each group who were all recruited from the same kindergarten; the first at pre-registration and the second at a later stage. As no contrasts were made between the cohorts it is possible that they could have been collapsed into one maltreatment group and a control group.

Kinard (1999) assessed the effects of child maltreatment, maternal depression and perceived social support upon children's social competence in sample of 334 mother-child pairs. No child-rated social competence differences were noted by maltreatment status between the two time points. However, maternal ratings of social competence, perceived peer support and maternal depression varied by maltreatment status (see Table 2.2). The contrast of recruiting via maltreatment reports and childcare services caused difficulty for this study as the two groups originated from differing populations. It is possible that parental ratings of social competence lacked validity due to potential biased views of their child in addition to possible deficits in their own social skills. Yet attention was paid to drop out and opt-in rates. Sixty percent of the quality criteria were achieved.

Rogosch, Cicchetti and Aber (1995) examined data from a longitudinal study which followed 89 children for three years during which time three sets of assessments were carried out. Social competence, aggression, peer rejection and understanding appropriate negative emotions significantly varied by maltreatment status, with the more negative outcome being typical of maltreated children (see Table 2.2). A thorough assessment process was employed with both peer and teacher raters and direct observations included. Drop-out and opt-in rates were not considered, nor was power analysis. A social competence composite was used to account for multiple contrasts but unfortunately this was poorly explored leaving their conclusions regarding social competence somewhat vague. Fifty-five percent of the quality criteria were met.

One longitudinal paper (Flores, Cicchetti & Rogosch, 2005) and four cross-sectional papers were carried out by the Mount Hope Family Centre team at the University of Rochester (Kim & Cicchetti, 2004; Manly, Cicchetti & Barnett, 1994; Manly, Kim, Rogosch & Cicchetti, 2001; Shields, Cicchetti & Ryan, 1994). These were all carried out within a summer camp context and used the same battery of assessments (see Table 2.2). While each of these studies has its' individual strengths and weaknesses the following points apply to all of the camp studies included in this review. Maltreated and control groups of children were recruited into the camp setting through different routes; maltreated children were identified from social work records of abuse and children without maltreatment experiences were recruited through adverts posted around low-income areas. While these groups were well-matched by socio-economic background they were recruited from different sources which places some uncertainty on potential factors which may not be accounted for. In addition, unlike the families of children without a history of maltreatment, the families of maltreated children were offered a small financial incentive to take part. Opt-in and drop-out rates were not stated and no attention was given to power analysis. However, the studies took place in an ecologically valid setting where counsellors and peers were able to base their ratings of target children upon 35 hours of contact with them.

The first of the summer camp studies presented examines the mediating role of social competence between mother-child relationship and problematic behaviour (Kim & Cicchetti, 2004). A longitudinal analysis of 345 children at summer camp revealed that maltreatment was associated with lower social competence and that this was associated with subsequent internalizing and externalizing symptomatology. Social competence was only reported by camp counsellors using the Pupil Evaluation Inventory resulting

in a measure relying upon adult perceptions of the children's 'likeability'. In addition, blinding of raters was not addressed. Fifty-seven per cent of the quality criteria was met.

### *Cross-sectional Studies*

*Indirect assessment of social competence.* Flores, Cicchetti and Rogosch (2005) report data from 133 Latino children attending research summer camps. Maltreated children were rated as less prosocial, more aggressive and more likely to be considered a fighter than non-maltreated peers. These results suggest that difficulties with peer interaction are as valid for children from this ethnic minority as children from white or African American backgrounds. Use of peer ratings and multiple raters of social competence added rigour to the study. Unfortunately, it was not clear how their composite social competence measure was constructed making it difficult to interpret their findings. Thirty-eight per cent of quality criteria were achieved.

The third summer camp paper examined the impact of subtype, frequency, chronicity and severity of maltreatment on social competence in a sample of 235 children (Manly, Cicchetti & Barnett, 1994). Maltreatment experience, its' frequency, severity and subtype all predicted social competence. Detailed maltreatment information was gained and a valid social competence assessment tool employed. Reliability of the social competence measure could have been increased through use of peer and self-ratings to support the ratings given by counsellors. The lack of this multi-rater checks and lack of thorough methodological design lowers the quality rating to 49%.

The fourth summer camp study (N=814) examined the influences of developmental timing and subtype on the consequences of maltreatment (Manly, Kim, Rogosch &

Cicchetti, 2001). Emotional maltreatment was associated with aggression, physical neglect with withdrawn behaviour and chronic maltreatment with the poorest outcome. A lack of co-operation, impulsivity and rigidity were common sequelae of maltreatment in general (see Table 2.2). This is the only camp paper assessed which acknowledged opt-in and drop-out rates, but unfortunately contrasts were not made between those in the study and those not opting in or those dropping out. Fifty-nine per cent of quality criteria were achieved.

Flisher, Kramer, Hoven, Greenwald, Alegria, Bird, Canino, Connell and Moore (1997) reported on a large scale (N=655) community study carried out in New York and Puerto Rico. They found physical abuse was associated with lower social competence but that this relationship was complicated by the presence of psychiatric disorders (see Table 2.2). Little elaboration on their findings was provided and opt-in, drop-out and power issues were not addressed. While the community sampling and multiple raters of social competence demonstrated robust methodology, the rating of assessment factors would have been higher if reliability and validity issues had been given more consideration. As a result only 48% of the rating criteria were achieved.

Levendosky, Okun and Parker (1995) used depression and maltreatment status to predict social competence and social problem-solving skills in a sample of 68 children. The authors stated that the majority of the sample was 'high-risk' due to poverty, physical abuse, neglect and negative life events. While they specify that 19 of the children had been physically abused within the two preceding years it is not clear how many of the children taking part had a history of maltreatment. Maltreatment status predicted adult ratings of social competence but not self-ratings, problem solving-skills



or attribution bias (see Table 2.2). While the reader is left with questions about the sample, design and assessment of social competence the paper provides an illuminating view of peer relationships. More transparent and rigorous sampling techniques and a consideration of power analysis would have raised the number of criteria met by this study. Nevertheless, 58% of the quality criteria were achieved.

Okun, Parker and Levendosky (1994) investigated the contributions of physical abuse, socio-economic disadvantage and negative life events upon social adjustment. Teachers, parents and children (N=68) completed subscales of related social competence questionnaires which were combined to form a peer adjustment summary score. Peer interaction adjustment was significantly poorer among those experiencing physical abuse and experience of negative life events (see Table 2.2). Some families of maltreated children were given additional financial incentives to encourage their participation in the study. This may have implications for recruitment ethics. It should also be noted that the authors commented that their sample of physically abused children had experienced “acts of harsh parental discipline” which may be a milder form of abuse than experienced by the wider population of abused children. While the analysis provided was illuminating it missed the opportunity to comment on any differences in social competence ratings by teachers, parents and children themselves. Unfortunately, power analysis was not considered in the sample size. Despite the use of multiple social competence ratings, clarity in use of composite scores and use of well-validated measures only 59% of quality criteria were met due to sampling concerns.

Rogosh and Cicchetti (1994) studied a sample of 115 school children using teacher and peer assessments of social competence and maternal ratings of parenting practices to

investigate links between family and peer relations. Maltreatment, especially physical abuse, was associated with lower social competence and more aggressive and withdrawn behaviour. While the number of subtypes of maltreatment experienced did not have a significant effect upon social competence this analysis was hampered by the small number of sexually abused children in the study and the hierarchical method of categorizing maltreatment limiting the number of children identified as being emotionally abused. Rogosch and Cicchetti achieved 48% of the criteria assessed due to poor sampling and analysis. While they were rigorous in their measurement of social competence they paid no attention to opt-in and drop-out rates, samples were recruited from different sources and demographic information was not reported for each sample.

Using peer and child ratings Salzinger, Feldman, Hammer and Rosario (1993) considered the effects of physical abuse on children's social relationships (N=174). Social preference scores, reciprocating friendships, being identified as a fighter, mean, disruptive, a leader and a sharer all varied by physical abuse status (see Table 2.2). These findings led Salzinger and colleagues to hypothesise that abused children may differentiate less clearly between supportive and non-supportive friends. Use of an explicit definition of maltreatment, basing the study within the ecologically valid social context of school, use of both standardized measures and peer ratings enabled this study to achieve 62% of the quality criteria. However, no consideration was paid to power and it may have been beneficial to split the data into two papers due to the amount squeezed into this one paper.

With a sample of 200 children Salzinger, Feldman, Ng-maak, Mojica and Stockhammer (2001) replicated the above findings regarding reciprocated friendships and took their

understanding further by examining the proposal that the diminished social status of physically abused children is mediated by cognitive and behavioural characteristics acquired within abusive environments. Maltreatment was associated with lower sociometric nominations, which were mediated by social expectations and behaviour. Some maltreated children demonstrated prosocial behaviour which led to a more positive social outcome (see Table 2.2). The authors noted that their model would benefit from further examination in a longitudinal study as evidencing causal links within a cross-sectional design is not possible. Despite these downfalls this paper used a rigorous design, was well grounded in relevant literature and provided a thorough and clinically relevant discussion of their findings. Sixty-two per cent of the quality criteria were achieved.

Shonk and Cicchetti (2001) used a composite score of social competence generated from a number of teacher rated assessments in investigating risk for academic and behavioural maladjustment following maltreatment (N=229). Maltreated children received lower social competence composite scores in comparison to peers (see Table ). Shonk and Cicchetti did not present data from the individual scales which produced the composite making the results somewhat difficult to interpret. Peer and observational ratings of social competence were not included. A total of 52% of criteria were achieved.

A contrast of physically abused, neglected and non-maltreated children and adolescents (N=139) was carried out by Wodarski, Kurtz, Gaudin and Howing (1990). A peer adjustment composite score was constructed from a number of other measures which was interpreted as a representation of social competence. Maltreatment was associated with peer adjustment problems and social withdrawal (see Table 2.2). While credit can

be given to the study for employing multiple raters of social competence the design, sampling, assessment, use of an undefined composite and analysis of both maltreatment and social competence lacked rigour resulting in only 24% of quality criteria being met.

*Inclusion of direct assessments of social competence.* Shields, Cicchetti and Ryan (1994) supplemented the summer camp battery of assessments with an observation of playground interaction. Social competence, aggression, use of situationally appropriate emotions and flexibility in social situations varied by maltreatment status (see Table 2.2). The ethics of gaining informed consent from participants (N=129) is questioned due to the use of incentives for children to opt-in to research activities during the camp. However, the more important criticism toward the study is the measure of social competence. While it is commendable that both direct and indirect measures were employed and two types of judges rated the behaviour there is little clarity about the formation of social competence composite scores developed. While the California Q-Sort is a standardised and frequently used measure the global social competence score was not detailed and little information was provided on the OBS-SOCIAL direct measure which had been developed for the study. Nevertheless, the high correlation between the two measures, the use of multiple raters and the ecologically valid context employed does suggest that the conclusions reached are valid. Fifty-two per cent of quality criteria were met.

Haskett and Kristner (1991) tested the hypotheses that abused children would initiate fewer appropriate play interactions and exhibit more negative behaviours in their peer interactions in comparison to nonabused age-mates. Indirect measures of social competence were completed by peers and teachers while the target children took part in

coded free-play sessions. Maltreated children were observed and rated as being less prosocial and more aggressive and withdrawn than peers (see Table 2.2). The use of multiple raters, inclusion of direct and indirect assessment tools and inclusion of inter-rater-reliability for their observation tool resulted in 69% of assessment criteria being met. If a clearer definition of maltreatment was included, more detail was offered on recruitment procedures and coding frame development, attention to response, drop-out rates and power of the sample were included additional quality criteria would have been met. It should be noted that this study had a small sample of 14 participants (see Table 2.1). Nevertheless, this interesting paper achieved 57% of the criteria assessed.

Howe and Parke (2001) studied friendship quality in a sample of 35 severely abused children residing in a residential treatment home using both direct and indirect assessment tools. Friendship dyads containing a maltreated child were distinguished from other dyads by gender, organised play, negative behaviour and perceived conflict and betrayal (see Table 2.2). They propose that a larger scale prospective longitudinal piece of work would be required to make causal links between competencies, therapeutic interventions and maltreatment experiences. No information was presented on response and drop-out rates or whether raters were blind to maltreatment status. There was also a lack of comparability between recruitment procedures for the two samples. Further, the only check for lack of maltreatment within the history of control children's maltreatment history was via the school headteacher. On another sampling issue, the residential status of the maltreated children limits the degree to which results can be generalised to the wider maltreated population. However, Howe and Parke were rare authors in that they carried out a power analysis, ensured they had sufficient

numbers for their analysis and used Bonferroni corrections to allow for multiple contrasts. Sixty-one per cent of quality criteria were met by these authors.

An observational study of 48 maltreated children's friendship interactions was carried out by Parker and Herrera (1996) using a series of tasks for friendship dyads. Children were recruited into this study from a study outlined above by Okun and colleagues (1994) (see above, Table 2.1 and Table 2.2). Dyads of maltreated children had difficulties staying on-task, dyads with maltreated girls expressed less positive affect and dyads with maltreated boys expressed more negative affect on specific tasks (see Table 2.2). Caution must be used in interpreting its results as their observation tool is yet to be supported as a valid and reliable instrument. Further, Parker and Herrera note that the codings relate to friendship dyads rather than individual children. This is especially important as the researchers were unable to ascertain if non-target children had an abuse history. This may have contaminated the results. Assessing children in interactions with friends in tasks they were familiar with, for example the game Perfection, created an ecologically valid context for assessing social competence. Particularly strong sampling and assessment scores resulted in 69% of all quality criteria being met.

### *Summary of results*

*Quality rating scores.* Table 2.3 displays scores achieved on the quality rating template. Fifteen of the papers reviewed achieved 50% and over of the quality criteria assessed which suggests that an acceptable level of methodological rigour was achieved.

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Insert Table 2.3 about here

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Sampling procedures were negatively skewed as the majority of papers did not sample maltreatment and control samples from comparable populations, did not detail opt-in and drop-outs and did not present sufficient demographic information on their samples. Further, poor quality was seen in relation to statistical procedure as the majority of papers did not carry out a power analysis, take precautions against multiple contrasts or achieve clarity in presentation of findings. A greater rigour and transparency was found in the design and assessment tools employed within the studies. Papers conducted by Salzinger and colleagues (1993, 2001), Parker and Herrera (1996) and Dodge, Pettit and Bates (1994) used the most rigorous sampling and assessment procedures and Dodge, Pettit and Bates (1994) and Salzinger and colleagues (2001) had the most robust designs.

#### *Inter-rater Reliability.*

An independent rater, blind to the primary ratings, also rated the papers using the framework presented in appendix 2.2. First and second raters achieved 80% inter-rater agreement. Sub-section score consensus was achieved for the four papers where an original discrepancy of more than 10% was reported. Negotiation on awarded ratings was within the sample and assessment sections. See Table 2.3 for a break down of the author's ratings for each paper and total percentage awarded for each paper by both raters.

## Discussion

### *Sample*

Three quarters of the papers recruited maltreated children and children without a maltreatment history through different routes. Maltreated children were recruited through social services and maltreatment records while control groups were accessed via schools, childcare facilities and through the use of adverts in low-income neighbourhoods. More robust recruitment procedures were employed by six papers who recruited children with and without a history of maltreatment from the same sources via kindergartens, school and community samples.

The majority of papers failed to include information on response rates to recruitment efforts and contrasts of individuals who opted-in to the study with the population targeted as a whole. This may have highlighted biases in recruitment strategies which omission of this information hides from the reader. In addition, the majority of studies failed to detail the number of participants leaving studies, or having incomplete information, and contrasts between these with individuals remaining in the study.

### *Assessment*

The greatest variability among papers was in assessment of social competence. Direct observation of social competence was only employed by four studies. Half of the papers did not include peer ratings of social competence while the majority gained ratings from several judges. While the use of multiple raters, and inclusion of peers within this, is beneficial in the assessment of social competence (Conaway & Hansen, 1989) the fact that none of the papers relied entirely upon parental ratings is promising. Unfortunately, few authors compared social competence ratings from different judges.



Three quarters of papers reviewed did not include published reliability and validity information on their social competence measures, however, the majority referred to their own reliability and validity checks – such as inter-rater reliability and internal consistency. A quarter of papers failed to ensure that raters were blind to the children's maltreatment status.

### *Operationalization of maltreatment and social competence*

A number of papers stated that social competence was being measured within their study but failed to provide a definition of this. Shonk and Cicchetti (2001) were the only authors to discuss the concept of social competence although some authors did use scales which focus upon the concept of social competence (see Appendix 4.3 for examples). Others focused on more circumscribed behaviours such as social withdrawal, aggression and peer rejection. Authors employing peer ratings and those assessing children within schools and summer camps recognised the ecological validity of these individuals as judges and the chosen situations as appropriate environments for assessing social competence.

Other papers developed social competence composite scores by combining numerous scores of a variety of tools. The development of such composites tackled the problem of having a large number of variables to explore which could have posed difficulties in analysis. Most of these studies failed identify the subscale scores entered into the composite and to elaborate on the meaning of the composite. This lack of clarity continues the difficulties previously reported in social competence research (Cavell, 1999; Conaway & Hansen; Cicchetti & Toth) which has made the transfer of research data across to clinical application problematic.

Definitions of maltreatment varied between studies. The majority distinguished between maltreatment subtypes whilst others concentrated on particular forms, particularly physical abuse. Sources of maltreatment information and the discrimination between different maltreatment experiences varied. Three quarters of papers in this review referred to official social work records to gain maltreatment information. While the majority of these authors used this information to identify subtypes of maltreatment others also gained information on frequency and severity through use of the Maltreatment Classification system (Barnett, Manly & Cicchetti, 1993) while some developed their own maltreatment rating scales (Dodge et al., 1994; Flisher et al. 1997).

Thorough classification of maltreatment types is important in contrasting potentially different outcomes for each. However, this is complicated by the frequent co-occurrence of each type. The ‘co-morbidity’ of maltreatment subtypes was managed in different ways. One cluster of authors took a hierarchical perspective while others did not acknowledge multiple maltreatment types.

*Summary of findings on the social competence outcomes associated with maltreatment*

The majority of information on maltreatment subtypes related to physical abuse. Physically abused children were found to have lower social competence in comparison to controls (Flisher et al., 1997) and neglected peers (Rogosch et al., 1994). These children received fewer best friend nominations, were less likely to have reciprocated friendships (Salzinger et al., 1993, 2001), were more likely to be rejected (Rogosch et al., 1995) and receive negative ratings from identified friends (Salzinger et al., 2001). Further, while they were able to gain friends when younger they had difficulty

maintaining these friendships over time (Bolger et al., 1998). Teachers and peers rated physically abused children as being more aggressive and disruptive (Manly et al., 2001; Salzinger et al., 1993, 2001) in addition to having less control over their negative affect - which was associated with poorer behavioural control and subsequent peer rejection (Rogosch et al, 1995).

Manly and colleagues (1994) found that sexually abused children have more social competence difficulties than both physically abused and neglected children. Emotional maltreatment was associated with having fewer playmates (Bolger et al. 1998) and increased aggression, especially following emotional maltreatment in infancy (Manly et al., 2001). Physical neglect, especially in infancy and pre-school years, was associated with later withdrawn behaviour (Manly et al., 2001).

Bolger and colleagues (1998) found that chronic maltreatment was associated with poor popularity with peers, poor friendship quality and few friends in comparison to children experiencing shorter living maltreatment. An inverse relationship was also found between maltreatment severity and frequency whereby increases in frequency of mild maltreatment has the greatest negative impact on social competence while increases in frequency of high severity maltreatment has little effect on social competence over and above the impact of a single high severity incident (Manly et al, 1994).

### *Statistical Analysis*

Only two papers paid attention to power analysis while half of the papers made attempts to control statistically for the multiple contrasts being employed through statistical measures or by the formation of composite scores.

### *Influence of previous reviews*

Conaway and Hansen (1989) identified a number of methodological difficulties inherent within social competence research with maltreated children. This review suggests that a number of the issues they identified have been addressed by subsequent research. Four of the reviewed studies employed observational assessments, 11 papers included peer ratings, three-quarters employed multiple raters, efforts were made by the majority to match participants by socio-economic and family factors and six of the included studies employed a longitudinal design. Considering this information it seems that suggestions made by Conaway and Hansen (1989) were employed by researchers in the field.

However, the same response was not noted for Tricket and McBride-Chang's (1997) suggestions relating to standardisation, validity and reliability of measures. At the assessment tool level some papers would benefit with more reference to validity and reliability issues. However, the use of composite scores is potentially a more important issue. While these are useful when analysing multiple factors this can result in losing the detail of the collected data and result in an excessively global assessment of social competence. In addition, while not taken up by the majority of researchers, a small number did detail the influence of developmental stage at which maltreatment occurs and a quarter of papers reported that their raters were blind to maltreatment status.

### *Reviewers' conclusions*

The majority of recommendations made by previous reviews have been acted upon within recent research. Increasingly specific maltreatment classification tools and measures assessing specific aspects of social competence are being employed. This has

importance for clinicians as the additional detail allows interventions to be targeted to the specific social development needs of individual children. Indeed, the use of peer ratings and observational methods have identified that maltreated children possess some social skills which can be built on while identification of areas which they find more challenging can assist clinicians in providing appropriate support. Authors should continue to use the range of social competence assessment tools employed within the papers reviewed. However, additional care should be taken in choosing the most relevant tool depending on whether a global or detailed picture of social competence is desired. There is now a vast amount of research which has located global deficits in social competence among maltreated children. Researchers should consider it a priority to focus on the detail of the social difficulties to focus attention on supporting the social development of this group of children.

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Figure 2.1 Diagram illustrating literature search process

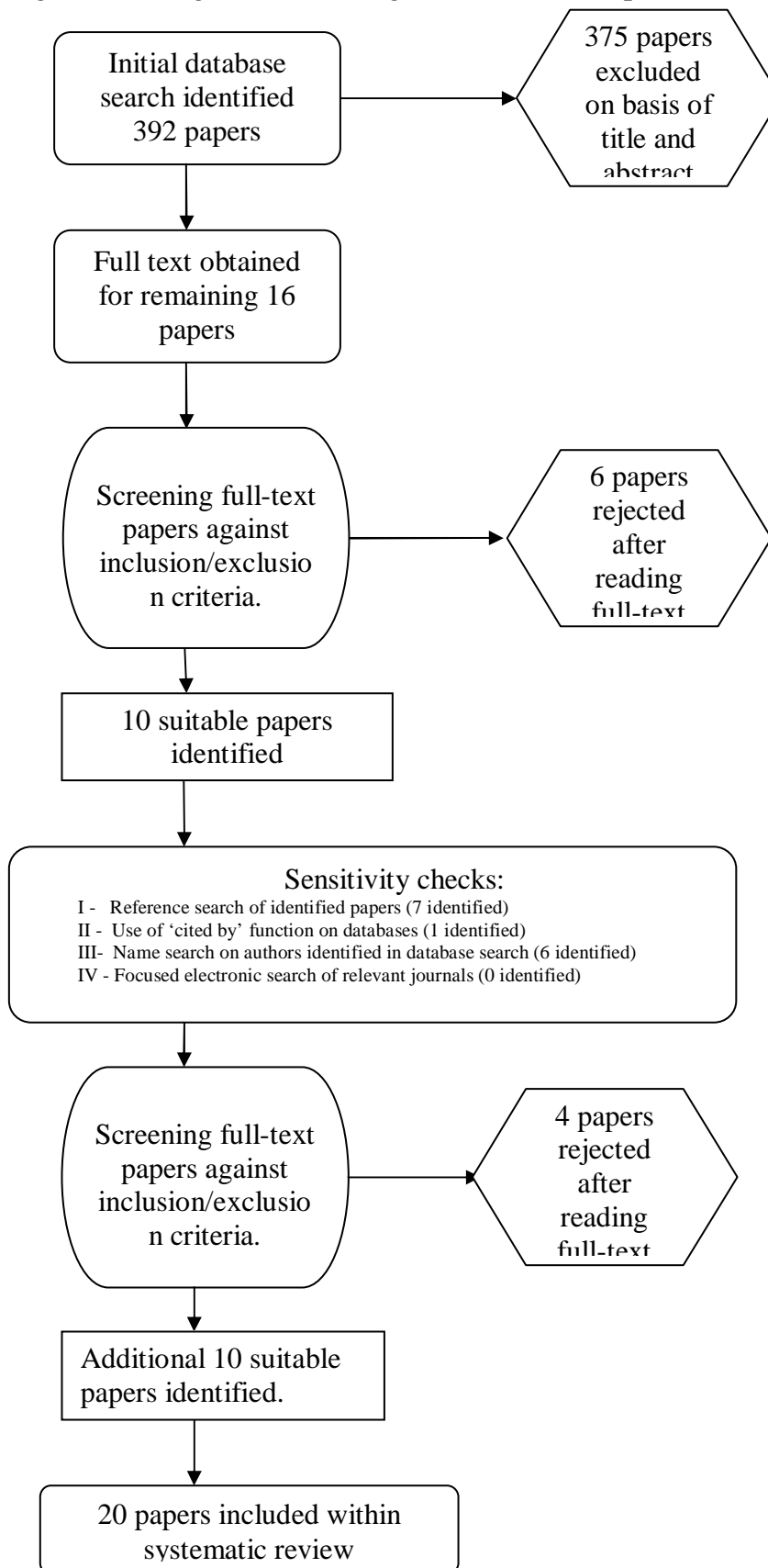


Table 2.1 Description of studies analysed in systematic review

Study / Design	Sample Characteristics	Recruitment Method	Data Collection Method
Bolger, Patterson & Kupersmidt, 1998 - longitudinal	N=214 (107:107) Community sample GENDER: 56 Male, 52 female AGE: 8-10yrs ETHNICITY: 60% white, 43% African American SES: low income VARIABLES CONTROLLED FOR: age, gender, ethnicity, school attended, low income status, MT chronicity	MT: matched names on Child Abuse and Neglect Information System to those in Charlottesville Longitudinal Study (CLS)  NON-MT: matched child from CLS N=32 excluded from analyses as identified as maltreatment starting during the study OPT-IN: Not stated	Data from Charlottesville Longitudinal Study conducted 1986-1989 – procedure detailed in Patterson, Kupersmidt & Griesler. 1990) BLIND: Not stated DROP OUT: Not stated
Dodge, Pettit & Bates, 1994 - longitudinal	N=585 (68:517) AGE: 5yrs at recruitment GENDER: 52% male ETHNICITY: 82% Caucasian SES: range skewed towards higher end of Hollingshead Index VARIABLES CONTROLLED FOR: socio-economic status	Parents approached at kindergarten registration for a longitudinal study of child development MT: parental interview inc. PA history OPT-IN RATES: 70% of contacted parents agreed to participate, those not pre-registering were contacted on first day of school. 2 cohorts (April 1988, April 1987) \$20 1 <sup>st</sup> interview, \$10 each assessment	LOCATION: not stated BLIND: peers, parents DROP OUT: 0% 1 <sup>st</sup> follow-up (FU), 3.2% 2 <sup>nd</sup> FU, 5.8% 3 <sup>rd</sup> FU, 8% 4 <sup>th</sup> FU, 11.3% 5 <sup>th</sup> FU
Flisher, Kramer et al., 1997 - cross sectional	N=665 (172 :493 ) GENDER: Female 57%:50% AGE:9-17yrs ETHNICITY: White 12%:9%, Hispanic 63%:47%, African American 20%:39% VARIABLES CONTROLLED FOR: family income, family psychiatric history, perinatal problems, physical health, SA	MT + Non-Mt: Community probability sample PA reported in 25.9% of MECA sample caretakers, NY State + Puerto Rico Methods for the Epidemiology of Child and Adolescent Mental Health Disorders (MECA) Study OPT-IN: not stated Child and caregiver received monetary compensation	LOCATION: simultaneous interviews with child and caretaker at home BLIND: not stated DROP OUT: not stated
Flores, Cicchetti & Rogosch, 2005 - cross sectional	N=133 (76:57) AGE: mean 8.68yrs GENDER: Male 56 Male: 36 ETHNICITY: Latino SES: Hollingshead rating level 1 + 2 = 90%: 81.6%, receiving public assistance 89.9%: 76.6% VARIABLES CONTROLLED FOR: age, gender, number of adults + children in home, socio-economic status, public assistance	Latino children from New York attending a summer day camp research programme 1986-2000. MT: Monroe County Dept. Human and Health Services (MCDHHS) records NON-MT: receipt of Aid to Families with Dependent Children + adverts in neighbourhoods of the MT children OPT-IN: not stated	LOCATION: Ratings carried out by camp counsellors and peers following a week-long summer camp BLIND: not stated DROP OUT: not stated
Haskett & Kristner, 1991 - cross sectional	N=28 (14:14) AGE: 3-6yrs GENDER: Male 9:9 ETHNICITY: Black N=8:8, White =6:6 SES: monthly income \$767(s.d.\$733):\$1,228 (s.d.\$871) MATCHED ON: age, gender, race, IQ, marital status of primary caregiver, relationship with guardian, consistency of living arrangements, no. siblings, maternal education, income	Mainstream day-care services MT: no abuse reported in the 6mth prior to taking part NON-MT: Selected from same classrooms as MT participants OPT-IN RATES: not stated	LOCATION: Day-care BLIND: observers, peers + teachers DROP OUT: not stated
Howe & Parke, 2001 - cross sectional	N=78 (35:43) AGE:4-11 yrs (mean 8.7 yrs) GENDER: Male 22: 23 ETHNICITY: Euro-American 51%:73%. African American 20%:3%, Latino 9%:19% SES: low-middle working class town VARIABLES CONTROLLED FOR: age, gender, majority/minority status	MT: residential home for abused and neglected children NON-MT: matched peers from MT children's elementary school, School principal confirmed NON-MT group have no history of family violence OPT-IN: not stated	LOCATION: school, residential home and screening facility. BLIND: not stated DROP OUT: not stated
Kim & Cicchetti, 2004 - longitudinal	N=345 (206:139) AGE: 7-12 yrs (Mean 9.18yrs) GENDER: Male 136:84 ETHNICITY: African American 56%:73%, European American 30%:16%, Latino 13%:9% (p<.05) SES: 85% MT, 82% non-MT 2 lowest strata (Hollingshead, 1975) MATCHED ON: age, SES, parental marital status (71% in single parent families) Families on welfare aid: 84%: 75% (p<.05) NB. Ethnicity + family aid not significantly related to outcome factors so not controlled for in subsequent analyses.	Children from New York attending a summer day camp research programme 1989-2000 with data on mother-child relationship, self-esteem, social competence and behaviour problems for 2 consecutive yrs. MT: Monroe County Dept. Human and Health Services (MCDHHS) records NON-MT: receipt of Aid to Families with Dependent Children or temporary assistance to needy families OPT-IN: not stated Children received a small prize for participation.	See Flores, Cicchetti & Rogosch, 2005

Table 2.1 contd.

Study / Design	Sample Characteristics	Recruitment Method	Data Collection Method
Kinard (1999) - longitudinal	N=334 mother-child pairs (165 mother-child pairs = MT, 169 pairs = non MT) GENDER: 47.5% male, 52.5% female AGE: mean 9 years (7-12 yrs) SES: ranking of neighbourhood (approx. 55% low-middle) MATCHED ON: age, ethnicity, SES, birth order, family structure GROUP DIFFERENCES: Maternal education 12 yrs +: MT < non-MT (p<.0001) Maternal employment: MT < non-MT (p<.0001) Welfare income: MT > non-MT (p<.0001) [N>PA or SA, p<.05] 8 of MT group and 1 of control group children not with birth mother	MT GROUP: From reports of MT filed over 3 years in two geographic catchment areas at a state child protection service. Contacted 4 months after index MT report. NON-MT GROUP: Families receiving childcare services in selected towns, excluded if MT reports exist OPT-IN RATES: 40.2% of all PA families opted in 37.3% of all N families opted in 32.8% of all SA families opted in Mothers paid \$25, children given gifts at each interview	LOCATION: Mothers mostly interviewed at home, Children mostly interviewed at school (Questions read aloud) BLIND: Interviewers blind to goals DROP OUT: 87.3% of MT mother-child pairs, 94.4% of nonMT group completed interviews at both time points (1 yr apart)
Levendosky, Okun & Parker (1995) - cross sectional	N=68 of which N=19 PA in last 2yrs (5 of which were also neglected) GENDER: 33 girls, 33 boys AGE: 8-12 years SES: 31% skilled craftsman, 31% machine operators and semi-skilled, average family annual income \$20,690 ETHNICITY: 75% Caucasian, 16% African American, 6% other racial groups CONTROLLED FOR: none stated	RECRUITMENT METHOD: MT GROUP: Adverts in low-income neighbourhoods, Records in Michigan Dept. of Social Services, Protective Services records to identify MT history, Specified elementary school NON MT GROUP: filers and elementary school only OPT-IN: not stated	LOCATION: Separate home interview with child and primary caregiver (questions read aloud), postal questionnaires for teachers BLIND: not stated DROP OUT: not stated
Manly, Cicchetti & Barnett, 1994 - cross sectional	N=235 (MT=90 Non-MT=145) AGE: 5-11 yrs (mean 8.07 yrs) GENDER: not stated ETHNICITY: not stated SES: low MATCHED ON: age, gender, SES MT>Non-MT no. children in house, years on state financial aid / Non-MT>MT maternal education. → controlled for in analysis	Children from New York attending a summer day camp research programme over a 2yr period. MT: Monroe County Dept. of Social Services (DSS) NON-MT: poster in welfare offices housing projects and neighbourhoods similar to MT sample + telephone screening verified by DSS record screening OPT-IN: not stated	LOCATION: NY week-long research summer camp BLIND: Yes DROP OUT: not stated
Manly, Kim, Rogosch & Cicchetti, 2001 - cross sectional	N=814 (492:322) AGE: 5-11 yrs (mean 7.36yrs:7.73yrs) (p<.001) GENDER: Male MT 63% NON-MT 60% ETHNICITY: Non-white 66%:76% (p<.001) SES: Family Hollingshead (<level2) 86%:85%, receiving public assistance 77%:80% (p<.01) MATCHED ON: gender, no. adults in home, SES, parents marital status	Children from New York attending a summer day camp research programme between 19886 – 1999 (1 <sup>st</sup> yr of attendance only) MT: unclear, Maltreated children attending camp (via state records?) NON-MT: families receiving state financial aid, confirmed non-MT via state records OPT-IN: not stated	LOCATION: NY week-long research summer camp BLIND: yes DROP OUT: N=68 excluded due to incomplete measures, N=8 excluded due to poor camp attendance, N=23 excluded as out of age range
Okun, Parker & Levendosky, 1994 - cross sectional	N=68 (19:49) AGE: 8-12 yrs (mean 10yrs) GENDER: Male 8:27 ETHNICITY: White 74%:76% SES: annual family income \$20,640: \$20,710 MATCHED ON: Family size, income, SES, race, age Significant differences on: MT>NON-MT married fathers as main caretaker	MT: Michigan Dept of Social Services (DSS), PA substantiated in last 2.5yrs (and no more recently than 10mths), PA primary type of abuse, no SA documented, perpetrator member of household. Parents given \$20-\$40 depending on reticence to take part. Children received a toy. NON-MT: adverts in low-income neighbourhoods, sent to food stamp recipients, letters to elementary school children. DSS records checked re: any substantiated abuse. Parents given \$20. Children received a toy. OPT-IN: not stated Teachers \$10 payment	LOCATION: home BLIND: teachers DROP-OUT: not stated
Parker & Herrara, 1996 - cross sectional	N=48 target children (16:32) + nominated best friends (N=48) AGE: mean 10yrs GENDER: Male 9:17 ETHNICITY: Caucasian 63%:81% Black 25%:9% SES: Gross family income \$23,840:\$23,500 VARIABLES CONTROLLED FOR: age, SES, family income, economic privation, observer rating of physical adequacy of home, number of recent stressful events, family size, gender, ethnicity, family structure, government assistance MT group scored significantly lower on verbal intelligence test.	Recruited from previous study (Okun et al., 1994) MT: Originally recruited via. State protective services records Non-MT: elementary schools, filers in low-income neighbourhood + to families receiving government assistance, state records clarified absence of MT OPT-IN RATES: 20 did not opt-in to this study - Post hoc tests → no sig. difs from recruited sample.	LOCATION: ID friend in phone interview PSN + FCC + observation period in testing environment in a motor home BLIND: teachers DROP OUT: no significant differences to final sample (those dropping out or with incomplete data)

Table 2.1 contd.

Study / Design	Sample Characteristics	Recruitment Method	Data Collection Method
Rogosch, Cicchetti & Aber, 1995 - longitudinal	N=89 (46:43) AGE: mean 5yrs at first assessment GENDER: 60% girls ETHNICITY: 10% minority race SES: low MATCHED ON: lowest SES levels, low income, high receipt of welfare, mothers with less than high school education	MT: Harvard Child Maltreatment Project (short-term longitudinal study) – those completing measures of interest over 3 time periods - originally recruited through Massachusetts Dept. of Social Services NON-MT: adverts in welfare offices + stores in low-income neighbourhoods - verified Non-MT status via telephone interview + official records OPT-IN: not stated	LOCATION: laboratory, school BLIND: teachers, peers DROP OUT: not stated
Rogosch, Cicchetti (1994) - Cross sectional	N=115 (59:56) GENDER: 65 girls, 50 boys AGE: 6-11 years SES: no significant differences using Hollingshead index, maternal education and receipt of family aid ETHNICITY: 12% minority race MATCHED ON: SES, maternal education, family status, number of children at home, receipt of family aid [NON-MT>MT maternal employment, p<.05]	RECRUITMENT METHOD: MT GROUP: Massachusetts Dept. of Social Services. NON-MT GROUP: adverts in welfare offices in low income areas, NON-MT status verified via telephone interviews + state records OPT-IN: not stated	LOCATION: Administered in school BLIND: Respondents were unaware of MT focus of study, Peers were unaware of identity of target child DROP OUT: not stated
Salzinger, Feldman, Hammer & Rosario, 1993 - cross sectional	N=174 (87:87) AGE: 8-12 yrs (mean 10 yrs) GENDER: ETHNICITY: Black 52%:42%, Hispanic 43%:49%, White 5%:9% SES: mothers on welfare support 51%:42% MATCHED ON: age, ethnicity, maternal education, single parent family, welfare variables	MT: 4yr cohort of consecutive entries on NY State Child Abuse + MT Register NON-MT: matched classmate of MT, checked not on above register, ID from class register OPT-IN RATES: half of families on register were contactable, half of these opted-in → 25%. No differences to those not opting in. \$100 per family	LOCATION: peer measures at school BLIND: school teachers + principals + control families + researchers in contact with families DROP OUT: not stated
Salzinger, Feldman, Ng-mak, Mojica & Stockhammer, 2001. - cross sectional	N=200 (100:100) AGE: 9-12 yrs GENDER: male 65:65 ETHNICITY: 47% black, 43% Hispanic, 7% white SES: mean occupation status (Nam-Powers index) mother 33:29, partner 42:37 MATCHED ON: gender, age, race, ethnicity, SES	MT: entries on NY state Register for Child Abuse 1992-1996 (not SA) NON-MT: case-matched classmates, screened for MT in interview with child's caretakers + scan of abuse register OPT-IN RATES: 28% (124 families unable to contact, 130 families refused) – similar to opt-in sample on most demographics.	LOCATION: peer ratings in class, child interviews at school, interviews with caregivers at home BLIND: teachers only DROP OUT: none identified
Shields, Cicchetti & Ryan, 1994 - cross sectional	N=129 (81:48) AGE: 8-12yrs GENDER: male 52:32 ETHNICITY: minority race 75%: 70% SES: family income \$16,477:\$18,1222 MATCHED ON: SES, % receiving family aid, single vs. Two parent household Significant differences on maternal education, maternal employment, no. Children in household	6 x 1week summer camp sessions MT: Monroe County Department of Social Services (DSS) NON-MT: radio announcements, posters in welfare offices, housing projects, neighbourhood businesses (verified by DSS records) Kids given points to exchange for small prizes if took part in research activities OPT-IN RATES: not stated	LOCATION: summer camp BLIND: Yes DROP OUT: not stated
Shonk & Cicchetti, 2001 - cross sectional	N=229 (146:83) AGE: 5-12 yrs (8 yrs) GENDER: male 65%:55% ETHNICITY: 48% African American, 40% European American, 9% Hispanic SES: low, 84% receiving state financial aid for 7yrs MATCHED ON: yrs receiving state aid, SES, no. adults in home, maternal education, single parents	MT: Department of Social Services: mail, home visits NON-MT: posters in welfare offices in + low-income neighbourhoods, absence of MT screened at interview (→N=18 reassigned to MT group) OPT-IN RATES: not stated	LOCATION: school BLIND: teachers DROP OUT: not stated
Wodarski, Kurtz, Gaudin & Howing, 1990 – cross-sectional	N=139 (69:70) AGE: 8-16yrs (mean 12 yrs: 11 yrs) GENDER: Male PA 41%, N 43%, NON-MT 54% ETHNICITY: White PA 55%, N 81%, NON-MT 63% SES: Semiskilled PA 69%, N 62%, NON-MT 47%; income <\$10,000 PA 58%, N 81%, NON-MT 26% MATCHED ON: gender, age	MT: Social work case workers identified eligible children NON-MT: randomly selected children in public schools OPT-IN RATES: not stated  Caseworkers, children + parents paid nominal sums for participation	LOCATION: school BLIND: YES DROP OUT: not stated

Note: Where two figures are presented as '43:84', the first figure refers to maltreated group and the latter the non-maltreated group PA = physical abuse, SA = Sexual abuse, N = Neglect, MT = maltreatment, NON-MT= no maltreatment, SC=social competence.

Table 2.2 Methodology of included studies

Study	Maltreatment Measures	Social Competence Measures	Results
Bolger, Patterson & Kupersmidt, 1998 - longitudinal	OFFICIAL REPORTS: yes + interview info STANDARDISED MEASURES: Maltreatment Classification System (Barnett et al., 1993) MT BREAKDOWN: subtypes: PA (51), SA (32), N (failure to provide N=52; lack of supervision N=69), EMT (N=32) (some children reported multiple subtypes)	CHILD + PEERS: Sociometrics - social preference score (Coie, Dodge & Coppotelli, 1982), Network of Relationships Inventory (Furman & Buhrmester, 1985) → friendship quality score + friendship conflict score + best friend Name playmates (checks for reciprocity)	<ul style="list-style-type: none"> <li>Chronic MT = less popular</li> <li>PA = greatest friendship quality at time 1</li> <li>Good friendship quality or reciprocal best friends mediated effects of chronic MT</li> <li>EMT associated with fewer reciprocal playmates, especially with earlier onset.</li> <li>Children whose parents failed to provide had fewer reciprocated playmates</li> <li>Lack of parental supervision associated with more peer conflict</li> </ul>
Dodge, Pettit & Bates, 1994 - longitudinal	OFFICIAL RECORDS: no STANDARDISED MEASURE: rating scale on probability of PA following maternal interview (inter-rater reliability .62-.70) MT BREAKDOWN: 100% PA, 6 cases suspected of ongoing PA at time of assessment	PARENTS: home interviews with parents, Child Behavior Checklist (CBCL) – social withdrawal scale TEACHERS: Child Behavior Checklist – Teacher Report form (TRF) – Unpopular Scale (\$5) PEERS: sociometric interview (Coie, Dodge & Coppotelli, 1982) → popularity rating, social preference score	<ul style="list-style-type: none"> <li>MT associated with poorer social preference scores, lower popularity ratings</li> <li>Girls had significantly higher popularity ratings than all boys.</li> <li>Twice as many MT children met criteria for peer rejection.</li> <li>Teachers + mothers rated MT children as less popular.</li> <li>Differences by MT status widened throughout study suggesting 2 developmental pathways</li> </ul>
Flisher, Kramer et al., 1997 - cross sectional	OFFICIAL REPORTS: no STANDARDISED MEASURES: new tool developed MT BREAKDOWN: PA only; 18% hit very hard, 4% beaten or kicked, 3% locked in a room, 3% physical injury, 3% badly punished, 4% hurt badly by an older person	CHILD: Instrumental and Social Competence Scale - social competence subscale, 9 youth items PARENT: Instrumental and Social Competence Scale - social competence subscale, 12 parent items	<ul style="list-style-type: none"> <li>PA associated with lower SC</li> <li>Psychiatric disorder was also associated with SC which cancelled out the PA relationship</li> </ul>
Flores, Cicchetti & Rogosch, 2005 - cross-sectional	OFFICIAL REPORTS: yes STANDARDISED MEASURES: Maltreatment Classification System (Barnett et al., 1993) MT BREAKDOWN: 74.6% PN, 66.2% PA, 15.5% SA. 77.6% multiple types of MT	PEERS: Peer Nominations (PN) COUNSELLOR: Behavior Ratings (BR), Pupil Evaluation Inventory (PEI), Teacher Report Form of the Child Behavior Checklist (TRF), California Child Q-Sort (CCQ), Student-Teacher Relationship Scale (STRS) <i>Indicators of social competence:</i> Scores summed to develop Prosocial, Aggressiveness and Resilience scores	<ul style="list-style-type: none"> <li>Counsellors rated MT Latino children rated as less prosocial and more aggressive</li> <li>Peers considered MT children more likely to be a fighter than non-MT children</li> </ul>
Haskett & Kristner, 1991 - cross sectional	OFFICIAL RECORDS: agency and childcare records STANDARDISED MEASURE: no MT BREAKDOWN: bruise, bone fractures N=11 mother perpetrator, N=3 father perpetrator	CHILD: 3x 10min free-play sessions with 6 peers. Coded for social initiation, peer reciprocation, instrumental aggression, hostile aggression, negative verbalisation + rough play PEERS: Sociometric ratings (Asher, Singleton, Tinsley & Hymel, 1979) TEACHER: Preschool Behavior Questionnaire	<ul style="list-style-type: none"> <li>Significantly fewer prosocial interactions with peers + significantly more negative peer interactions (aggression) were seen in MT sample</li> <li>No difference by MT in number of interactions initiated</li> <li>Peers rated MT children as less well-liked and that they would likely reject approaches from these children</li> <li>Teachers rated MT children as more aggressive and withdrawn</li> </ul>
Howe & Parke, 2001 - cross-sectional	OFFICIAL REPORTS: no, residential home records (?) STANDARDISED MEASURES: no MT BREAKDOWN: onset mean 24mths, 68% PA, 68% N, 65% SA, 28% EMT, 5% Sexual exploitation, 37% in utero exposure 40% father perpetrator, 82% mother perpetrator	PEERS/CHILD: Sociometric assessments – Asher, Singleton, Tinsley & Hymel (1979) procedure FRIENDSHIP PAIRS: Friendship Quality Questionnaire OBSERVERS: Friendship Observation Scale → negative behaviour, proactive behaviour, organised play and dominance factors	<ul style="list-style-type: none"> <li>MT children reported their friendships as less caring and validating while also containing more conflict and betrayal</li> <li>MT boys displayed more negative behaviour + MT girls displayed less in comparison to non-MT peers</li> <li>MT children were less proactive in FS interactions</li> <li>MT boys used significantly less organised play than others while MT girls used significantly more in comparison to non-MT peers</li> <li>No difference in dominance in FS pairs conflict resolution, providing help ad guidance, spending quality time</li> </ul>
Kim & Cicchetti, 2004 - longitudinal	See Flores, Cicchetti & Rogosch, 2005 MT BREAKDOWN: 60% EMT, 74% N, 33% PA, 12% SA. 64% multiple types of MT, 97% mother named as perpetrator for some form of MT	COUNSELLORS: Pupil Evaluation Inventory	<ul style="list-style-type: none"> <li>SC varied by MT status</li> <li>SC was associated with internalizing and externalizing terminology</li> </ul>



Table 2.2 contd.

Study	Maltreatment Measures	Social Competence Measures	Results
Kinard, 1999 - longitudinal	OFFICIAL REPORTS: yes STANDARDISED MEASURES: no MT BREAKDOWN: If PA + SA classified as SA (N=6), If PA + N classified as PA (N=18)  Mothers were perpetrators in 65.5% of families	CHILD: Self-Perception Profile for children (Harter, 1985a) – social acceptance subscale PARENT: Achenbach Child Behavior checklist (classified scores into clinical or normal range: $\geq 30$ normal, $\leq 29$ clinical)	<ul style="list-style-type: none"> <li>Maternal ratings of MT children's SC were significantly poorer than other children.</li> <li>Child reported SC did not differ by MT status</li> <li>Lower peer support was associated with lower maternal ratings of SC</li> <li>Mothers of MT children self-reported greater depression.</li> <li>MT status and maternal depression predicted 13.4% of maternal SC ratings.</li> <li>Higher perceived peer support was associated with greater SC.</li> </ul>
Levendosky, Okun & Parker, 1995 - cross sectional	OFFICIAL REPORTS: yes, mean 2.78 (SD=1.77) reports per child STANDARDISED MEASURES: no MT BREAKDOWN Majority = beatings with a fist, belt or paddle, or kicked. 40% abused by a parent	CHILD: Self-Perception Profile for children (SPPC), Harter, 1985 PARENT/TEACHER: Ratings of Child's Competence (RCC)	<ul style="list-style-type: none"> <li>Children's depression scores predicted all SC ratings</li> <li>MT status only predicted teacher and adult rated SC</li> <li>MT did not predict social problem solving or attribution bias differences</li> <li>MT girls reported higher SC than non-MT peers</li> </ul>
Manly, Cicchetti & Barnett, 1994 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURES: MCS, Barnett et al., 1993 MT BREAKDOWN: SA=26, PA (without SA)=72, N (without SA or PA)=47 (EMT=4 – eliminated as group too small), 81% multiple subtypes N.B. siblings of MT children where no formal records of MT existed but MT was suspected were also included in the MT group.	CAMPLE COUNSELLOR: California Child Q-set	<ul style="list-style-type: none"> <li>MT experience, frequency and severity of MT predicted SC</li> <li>PA had a greater impact on SC than PA and N</li> <li>Increased frequency of high severity MT did not increase impact on SC</li> <li>Increased in frequency of moderate MT increased impact on SC and even more so with mild MT.</li> </ul>
Manly, Kim, Rogosch & Cicchetti, 2001 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURES: MCS BREAKDOWN: EMT 65%, PN 79%, PA 42%, SA 13%, multiple subtypes 64% DEVELOPMENTAL PERIOD OF MT ONSET: <3yrs 46%, 3-5 yrs 45%, >5yrs 9% Parent/family member typical perpetrator (88% mother)	COUNSELLORS: Teacher Report Form of Child Behavior Checklist, California Child Q-set, Behavior ratings PEERS: sociometric status (Coie & Dodge, 1983)	<ul style="list-style-type: none"> <li>Counsellor and peers rated MT children as more aggressive and less co-operative</li> <li>Counsellors rated MT children as more withdrawn and impulsive in behaviour and emotion while being less flexible</li> <li>EMT in infancy and PA in preschool years were associated with aggression</li> <li>PN was associated with withdrawn behaviour</li> <li>Chronic MT, especially in infancy or preschool years, was associated with more maladaptive outcomes</li> </ul>
Okun, Parker & Levendosky, 1994 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURES: no BREAKDOWN: 100% PA [majority=beaten with fist, belt or paddle, kicked, N=1 burnt, N=1 head trauma], 33% N also Multiple reports (mean=2.78 (s.d.=1.77) 1/3 abused by mothers only 1/3 abused by (step)father only 21% abused by both parents Only 1 child ever removed from family home due to PA	PARENTS + TEACHERS: CBCL, Ratings of Child's Competence CHILD: Self-perception Profile - Revised	<ul style="list-style-type: none"> <li>PA was associated with significantly more peer interaction difficulties</li> <li>Correlation between poor peer interaction and socio-economic disadvantage</li> <li>Increases in negative life events were associated with increased peer adjustment in disadvantaged children</li> <li>Decreases in peer adjustment noted in children from advantaged background after increased negative life experience.</li> </ul>
Parker & Herrera, 1996 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURES: no MT BREAKDOWN: PA only, N=5 PA+N, beatings with fist, belt or paddle, kicked, burnt All abuse perpetrated by parents	CHILD: identify best friend CHILD + BEST FRIEND: Peer Social Network diagram, Friendship Contact Checklist, Observation period (friendship discussion snack, game-playing), Friendship Attributes Q-Sort	<ul style="list-style-type: none"> <li>Dyads with MT girls expressed significantly less positive affect on talk centred tasks</li> <li>Dyads with MT boys expressed significantly more negative affect in competitive tasks</li> <li>MT dyads had significantly more difficulty staying on-task with more personal topics (e.g. nature of their FS)</li> </ul>
Rogosch, Cicchetti & Aber, 1995 - longitudinal	OFFICIAL RECORDS: yes STANDARDISED MEASURE: yes, Giovannoni & Becerra (1979) checklist MT BREAKDOWN: 85% EMT, 80% N, 54% PA, 4% SA, 83% more than one form	TEACHERS: Teacher's Rating Scale of child's Actual Behaviour, California Child Q-Set, PEERS: Revised Class Play	<ul style="list-style-type: none"> <li>Teacher and peer reported SC significantly varied by MT status</li> <li>MT children were more undercontrolled and aggressive than non-MT peers</li> <li>MT were significantly more avoided, isolated and rejected by peers</li> <li>MT children had more difficulty understanding expected emotional reactions</li> <li>Understanding appropriate angry or sad responses mediated relationship between MT and behaviour dysregulation</li> <li>Understanding negative affect mediated effect of PA on peer rejection</li> </ul>

Table 2.2 contd.

Study	Maltreatment Measures	Social Competence Measures	Results
Rogosch & Cicchetti, 1994 - cross sectional	OFFICIAL REPORTS: yes STANDARDISED MEASURES: Giovanni & Becerra (1979) checklist on social work records MT BREAKDOWN: N=3 SA, N=30 PA, N=23 N, N=3 EMT, 18.6% 1 form of MT, 40.7% multiple forms, 38.9% 3 forms, 1.6% all 4	PEERS: Revised class Play TEACHER: Teacher's Rating Scale of Child's Actual Behavior - focus on social acceptance subscale. California Child Q-Set	<ul style="list-style-type: none"> <li>Significantly lower teacher rated SC among MT, especially PA versus N</li> <li>Peers rated MT children as significantly more withdrawn and aggressive</li> </ul>
Salzinger, Feldman, Hammer & Rosario, 1993 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURES: MT BREAKDOWN: PA only. 78% excessive corporal punishment, 58% demonstrable physical injury, 16% PA+N	PEERS: Sociometric status – 2-choice procedure (Dodge, 1983), Peer ratings of social behaviour	<ul style="list-style-type: none"> <li>Significantly fewer positive and best friend nominations, more negative nominations and lower social preference score following PA.</li> <li>PA associated with significantly fewer reciprocating friends and best friends + more frequent negative rating from chosen friends</li> <li>All MT and non-MT received at least 1 positive choice from class mate</li> <li>Some MT children identified as popular and some non-MT children rejected</li> <li>Evidence of some prosocial behaviour among MT children</li> <li>Peers rated PA children as higher on fighting, meanness and disruption but lower on leadership and sharing.</li> </ul>
Salzinger, Feldman, Ng-mak, Mojica & Stockhammer, 2001 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURE: no MT BREAKDOWN: 100% PA, 60% PA+N	CHILD + PEERS: Measure of social expectations, Sociometric Nominations → social preference, positive reciprocity, peer rejection, negative reciprocity, Peer Ratings of Social Behaviour	<ul style="list-style-type: none"> <li>Sociometric nominations of MT children were mediated by their social interaction expectations and behaviour.</li> <li>MT children were significantly less likely to expect others to chose them positively and were also more aggressive and less prosocial with peers.</li> <li>For some MT children prosocial behaviour was a resilience protecting from a poor social outcome.</li> </ul>
Shields, Cicchetti & Ryan, 1994 - cross sectional	OFFICIAL RECORDS: Yes STANDARDISED MEASURE: no MT BREAKDOWN: N=36 PA, N=39 N, N=6 SA [ used hierarchy method] Only 1 child ever removed from family home due to PA	COUNSELLORS: Child Behavior Checklist – Teacher's Report Form, Behavior Ratings, California Child Q-Set → global rating of social competence INDEPENDENT RATERS: Observation of playground behaviour (OBS-SOCIAL)	<ul style="list-style-type: none"> <li>Significant difference in SC by MT status</li> <li>MT children were significantly more aggressive, displayed more situationally inappropriate emotion and were less flexible in interactions.</li> <li>Emotional and behavioural regulation mediated effect of MT on SC with peers</li> </ul>
Shonk & Cicchetti, 2001 - cross sectional	OFFICIAL RECORDS: yes STANDARDISED MEASURE: MCS, Barnett et al, 1993 MT BREAKDOWN: 60% EMT, 87% N, 59% PA, 21% SA	TEACHERS: Taxonomy of Problematic Social Situations for children (TOPS), Teacher's Checklist of Children's Peer Relationships and Social Skills (TCS), Teacher's Rating of Perceived Competence (TRPC) – <8yrs, Peer Acceptance Cognitive Competence subscale /Teacher's Rating Scale of Child's Actual Behavior (TRAB) – >8yrs, social acceptance subscale, Social competence data reduction: combination of all above	<ul style="list-style-type: none"> <li>Significantly lower SC composite score for MT children</li> <li>MT associated with poorer conflict resolution, prosocial skills and rejection with greater inappropriate responses to social situations</li> <li>MT has a negative effect on SC which has negative consequences for behavioural maladjustment.</li> </ul>
Wodarski, Kurtz, Gaudin & Howing, 1990 – cross-sectional	OFFICIAL RECORDS: no STANDARDISED MEASURE: no MT BREAKDOWN: N=22 PA, N=47 N	CHILD: Piers-Harris Children's Self-concept Scale	<ul style="list-style-type: none"> <li>MT children had more peer adjustment problems</li> <li>MT boys were more withdrawn.</li> </ul>

Note: PA = physical abuse, SA= sexual abuse, N=neglect, EMT=emotional maltreatment, MT = maltreatment, PN=Physical neglect, FS = friendships, SC = social competence.

Table 2.3 Quality ratings for each paper - including second rater.

Study	Aims & Procedure – max 5	Sample – max 6	Assessment – max 13	Statistical Analysis – max 5	TOTAL (%)	2 <sup>nd</sup> Rater Total %
Bolger, Patterson & Kupersmidt, 1998	5	2	7	2	55%	48%
Dodge, Pettit & Bates, 1994	5→3	4	10	2	72%→66%	45%→59%
Flisher, Kramer et al., 1997	4	2	6	2	48%	48%
Flores, Cicchetti & Rogosch, 2005	4	2	4	1	38%	48%→45%
Haskett & Kristner, 1991	3	2	9	2	55%	55%
Howe & Parke, 2001	3	1	8	5	59%	72% →66%
Kim & Cicchetti, 2004	5	2	6	3	55%	59%
Kinard, 1999	3	4	9	1	59%	59
Levendosky, Okun & Parker, 1995	4	0	11	2	59%	52%
Manly, Cicchetti & Barnett, 1994	4	1	7	2	48%	48%
Manly, Kim, Rogosch & Cicchetti, 2001	4	3	8	2	59%	62%
Okun, Parker & Levendosky, 1994	3	1	11	2	59%	55%
Parker & Herrera, 1996	3	5	9	3	69%	59%
Rogosch, Cicchetti, 1994	4	1→0	9	1	52%-48%	38%→41%
Rogosch, Cicchetti & Aber, 1995	5	2	8	2	55%	48%
Salzinger, Feldman, Hammer & Rosario, 1993	4	4	9	1	62%	52%
Salzinger, Feldman, Ng-mak, Mojica & Stockhammer, 2001.	4	4	8	2	62%	52%
Shields, Cicchetti & Ryan, 1994	4	1	8	2	52%	52%
Shonk & Cicchetti, 2001	4	1	7	3	52%	45%
Wodarski, Kurtz, Gaudin & Howing, 1990	1	1	4	1	24%	34%

## CHAPTER THREE: MAJOR RESEARCH PROJECT PROPOSAL

### A qualitative exploration of children's understanding of indiscriminate friendliness

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## Summary of Project

The proposed research aims to explore children's understanding of indiscriminate friendliness. A social interaction style characterised by social disinhibition can make it difficult for children to develop and maintain relationships. Further, this can leave children vulnerable to exploitation from strangers. This behaviour is characteristic of children who have been neglected and who have been cared for in 'Looked After and Accommodated Services'. Some of these children may attract a diagnosis of Reactive Attachment Disorder (RAD) whilst socially disinhibited children without such a background sometimes attract a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).

Semi-structured interviews will be employed to explore children's understanding of their indiscriminate friendliness which will be analysed using Interpretative Phenomenological Analysis. A deeper understanding of the behaviour will offer insights into ways in which clinicians may best support this group of vulnerable children.

## Introduction

### *What is social disinhibition?*

Zeanah, Smyke and Dumitrescu (2002) define indiscriminate behaviour as "a pattern of wandering off without checking back, failing to exhibit expectable reticence with unfamiliar adults, and being willing to go off with a stranger". This could be in a context of having a preferred attachment figure or in a context without a preferred attachment figure. Being friendly with new adults, approaching strangers (Chisholm,

1995) and a lack of differentiation among adults could also be added to this description (O'Connor et al., 2000). Indiscriminate behaviour, social disinhibition and indiscriminate friendliness are all terms which have been used to describe this style of interaction.

In the Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR, American Psychiatric Association, 2000) social disinhibition is described as indiscriminate sociability or a lack of selectivity in the choice of attachment figures. This disruption of social relatedness forms the description of the disinhibited subtype of Reactive Attachment Disorder (RAD). DSM-IV-TR describes this disinhibited behaviour as "being overly familiar with or seeking comfort from an unfamiliar adult caregiver" (p. 129, APA, 2000). The disinhibited subtype of RAD has typically been described among children who have been maltreated and those who have been institutionalised (Boris et al., 2005). Disinhibited behaviour is also seen in children who had received a diagnosis of Attention Deficit Hyperactivity Disorder, which, while being similar, is characterised as being more impulsive.

#### *Which children tend to be socially disinhibited?*

Research to date has looked at social disinhibition in children reared in institutions and children who have been fostered, adopted, neglected or abused (Albus & Dozier, 1999, Boris et al., 1998, 2000; Zeanah et al., 1993, 2000, 2001).

Tizard's work found that the greatest levels of indiscriminately social behaviour are seen in children who have been institutionalised for the greatest amount of time (Hodges & Tizard, 1989; Tizard & Rees, 1975). When institutionalised children

went on to be adopted the only significant difference between this group of children and those who had never been institutionalised was their higher level of 'overly friendly' behaviour. Similarly, Smyke, Dumitrescu and Zeanah (2002) found that the majority of children from institutions in their study were socially disinhibited whereas only 12% of similar-age contrast children who had never lived in an institution behaved in this way.

Indiscriminate friendliness is a persistent social difficulty for these children (Zeanah, Smyke & Dumitrescu, 2002). They identified what Chisholm termed 'indiscriminate friendliness' in children at a median of 11 months and 39 months post-adoption. Although security of attachment between child and primary caregiver significantly increased between these time points indiscriminate friendliness did not reduce (Chisholm, 1998).

### *Preferred caregiver and social disinhibition*

Chisholm's discovery of indiscriminate friendliness within the context of a secure attachment has been supported by Marvin and O'Connor (1999) who found that at the age of 6 years a number of children adopted out of Romania were assessed as being securely attached using the Strange Situation but they were also indiscriminately social. Chisholm (1998) concluded "that indiscriminate behaviour is not a sign of disordered attachment, instead, she suggested that it may well be an adaptive behaviour in the institutional setting and selectively reinforced after adaptation" (Zeanah, Smyke & Dumetrescu, 2002, p.983). Support for Chisholm's findings has been reported by Zeanah, Smyke and Dumitrescu (2002) who found that

while having a preferred attachment figure is associated with lower levels of social disinhibition having a preferred caregiver did not preclude indiscriminate behaviour.

### *Long-term consequences*

Disinhibited behaviour has been found to endure into early adulthood (Wolkind, 1974). For example, when Tizard followed up children who had lived in an institution for their first 2 years at 16 years their 'overfriendly' behaviour had lessened, yet there was evidence of significant peer relational problems (Hodges & Tizard, 1989). "Problems included being adult-orientated, having more difficulties in peer relations, not having a best friend, not turning to peers for support, and being less selective in choosing friends" (Zeanah et al., 2002. p. 984).

### *Proposed explanations of social disinhibition*

O'Connor and colleagues (2000) described indiscriminate behaviour as a manifestation of social boundary problems and as a sign of disinhibited attachment. Conversely, Chisholm (1998) has described indiscriminate behaviour as 'friendliness' which is not a disorder of attachment. Zeanah and colleagues (2000) add to this debate by questioning whether indiscriminate sociability is a sign of disordered attachment or if it is an independent problem which occurs in a context of emotional neglect.

The most characteristic feature of children reared in institutions is a lack of selectivity in social approaches and in comfort seeking (Chisholm, 1998; O'Connor et al., 1999, 2000). Roy and colleagues perceive such difficulties as a deficit in perception of social cues and in the appreciation of social boundaries rather than



indiscriminate friendliness 'per se' (2004). "The children seek social contact but do so in ways that are relatively unresponsive to social conventions and which are relatively non-differentiating with respect to the people to whom social overtures are made, and from who social advances are accepted" (Roy et al., 2004, p.871).

Alternatively, the 'brashness' of approaching any adult may be motivated by a craving for contact and to have one's needs met. "If the child's goal is contact with a potentially caring adult, approaching most adults with whom the child comes into contact would support that goal" (Smyke, Dumitrescu & Zeanah, 2002, p. 979).

In ADHD such behaviour may be less goal directed. Disinhibition theory relating to behaviour seen in children with Attention Deficit Hyperactivity Disorder could be applied to indiscriminate friendliness. Patterson and Newman (1993) propose that disinhibited behaviour stems from a lack of reflection on ongoing and current situations, especially in the face of goal frustration. Disinhibited children tend to forge ahead with their original plan of action rather than stopping to check out the situation.

### *Summary*

There is a growing body of research and theories in relation to indiscriminate friendliness. However, we do not know what life is like from the perspective of a socially disinhibited child, we don't have information about how they perceive their behaviour and the motivations they ascribe to this. Thus, this study aims to gather information about experiences of social disinhibition from children who are socially disinhibited themselves through the use of a semi-structured interview. This

information will be analysed with the aim of gaining an understanding of the phenomena of indiscriminate friendliness from the perspective of the children who behave in this way.

### *Aims*

This study aims to use qualitative methods to investigate children's experiences and understanding of their own social disinhibition. Semi-structured interviews and subsequent Interpretative Phenomenological Analysis<sup>2</sup> will be employed to achieve this aim.

## Plan of Investigation

### *Participants and recruitment*

Approximately ten children aged 8-16 years will be recruited. This is within the recommended sample size for IPA studies (Smith, Jarman & Osborn, 1999). A purposive iterative selection of children will be undertaken whereby specific individuals will be recruited due to their potential for adding to the understanding of social disinhibition. Older children will be interviewed where possible as they will likely be most able to reflect upon their behaviour. Further, prioritising children for interview who have differing degrees of indiscriminate friendliness according to the Relationships Problems Questionnaire (see measures section below) would potentially allow for the gathering of information from different experiences of social disinhibition.

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<sup>2</sup> As outlined in Smith, J.A. (1996) Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11, 261-271.

Indiscriminately friendly children will be identified by clinicians working at Yorkhill and in associated clinics. In particular, clinics for children with Reactive Attachment Disorder and clinics for Attention Deficit Hyperactivity Disorder will be targeted during recruitment. Further, members of Adoption UK- Scotland<sup>3</sup> will be provided with information about the study and offered the opportunity for their children to take part.

The carers or parents of each potential participant identified from Yorkhill sources will be sent a letter from myself and Dr Minnis accompanied by information about the study, an invitation for their child to take part and an opt in slip to return should they be happy for their child to take part. Opt in slips will request for contact details which are to be returned to the researcher along with a signed consent form from the parent. If the child is 12 years or over they will also be asked to sign a consent form. Signed consent for the interviews to be recorded will be requested from a carer or parent and assent from each child on attendance at the interview.

On the receipt of opt-in and consent forms the families will be sent out three questionnaires to be completed (see below), a list of potential venues for the interview and a choice of interview dates. These will include Yorkhill Hospital and health centres local to the family which have been contacted by the researcher where a room would be available. The family would be requested to return the completed questionnaires in a self-addressed envelope which they would be provided with and also an indication of their preferred interview venue. Where families do not attend the arranged interview they will be offered up to £20 in travel expenses, on provision

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<sup>3</sup> Adoption UK is a charity offering support information and advice to adoptive families before, during and after the adoption process.

of a receipt, if they attend a second arranged interview. Adoption organisations will receive recruitment fliers asking members to opt in to the study. These self-identifying individuals will be sent an information pack also.

### *Measures*

Three questionnaires will be mailed out to families once they have opted into the study. The Relationship Problems Questionnaire (RPQ, Minnis, Rabe-Hesketh & Wolkind, 2002) will be used to assess for the presence of social disinhibition. This will be completed by the parents of potential participants and returned to the researcher via mail. Further, parents will also be asked to complete the Strengths and Difficulties Questionnaire (SDQ, Goodman, 1999) to give an overview of emotional, conduct, hyperactivity difficulties along with an indicator of their social functioning. Children will be asked to complete the children's self-report version of this questionnaire.

Positive scores on the RPQ, i.e. a score of 1 or above (maximum possible score is 54), and positive scores on one or more subscales (maximum 10 for each subscale) of the SDQ will be the only requirement for children taking part in the study. Such positive scores on these questions suggests the possibility of some social difficulties. Including children who score widely, albeit positively, on these questionnaires will result in a broad range of children who may have different experiences of indiscriminate friendliness. This variety will encourage the possibility of a rich and varied amount of information being discovered about experiences of social disinhibition.

### *Interview Schedule*

The interview schedule will include a number of strategies which aim to encourage each child to speak about their experiences of being socially disinhibited. The strategies are intended to be used flexibly and creatively in order to best encourage the children taking part to be able to share their experiences of social disinhibition. The strategies outlined will be used much in the way that a Clinical Psychologist employs various techniques within clinical sessions to engage children.

The interview will commence with a gentle introduction about safe topics aiming to put the child at ease. These may include questions about things they like to do, a favourite game or subject at school. When the interviewer feels that the child is at ease the topic of 'friendliness' will be introduced as something that some people find easy but that for others it is more difficult. The interview would then go on to enquire about their experiences of friendship and being friendly. When examples of these are identified by the child these will be explored with probes about their feelings and thoughts about it. Some children may have difficulty simply speaking about their own experiences so they may be encouraged to draw a situation where they were being 'friendly'. Discussion would then revolve around the scenario they have drawn.

Where children have difficulty thinking of a situation where they may have crossed social boundaries with their indiscriminate friendliness the interviewer would introduce some pre-prepared scenarios of a child in such a situation. The child will be asked to imagine themselves in this situation and to explain what they might do and how they might be thinking and feeling. The interviewer will verbally present

these scenarios. These scenarios may be supplemented with pre-prepared illustrations.

### *Design and Procedures*

A semi-structured interview schedule will be constructed with reference to the existing literature on social disinhibition. Further, a list of approximately six relevant socially disinhibited scenarios will be generated via three focus groups. A group of professionals will brain-storm ideas for scenarios. This will include Dr Helen Minnis who has considerable experience of working with children with both RAD and ADHD, two teachers with a specialist interest in ADHD and a research nurse with a specialist interest in RAD. A 'real-life' perspective will be separately sought from the parents of children with RAD via focus groups. This aims to discover their perspective on situations in which their children are often socially disinhibited and thus will assure that there is a degree of ecological validity in the scenarios presented to the children. Six scenarios will be chosen from the ideas generated by the three focus groups to include within the interview schedule 'tool kit'.

The interview will be piloted on an adult and also with a child who is not typically socially disinhibited. This will allow for a live trial of the strategies which aim to explore the experience of indiscriminate friendliness. These pilots will be recorded and listened to as a training tool for the interviewer. These live trials may be repeated with different children and adults known to the researcher if further adaptation is thought necessary at this stage.

Recruitment of indiscriminately friendly children will start during the live trials of the interview schedule. Thus, pilot interviews with children who are identified as socially disinhibited can be commenced following the live trials. Data will be used from these pilot interviews but there will be scope to adapt the interview schedule during the earlier interviews as it is further adapted with the aim of establishing the best methods of eliciting information on social disinhibition. Each interview is expected to take approximately 30 minutes.

### *Settings and Equipment*

The children and their parents/carers will be met at Yorkhill Hospital or at an agreed health clinic local to the family. A tape recorder with microphone and blank cassettes will be required for each interview. Further, paper and colouring pencils will be needed for the interview sessions. In addition, a transcription machine will be needed for transcription purposes. If 10 children take part in the study it is estimated that this will result in five hours of taped interview time. Transcription of one hour of interview material typically takes between eight and ten hours to transcribe (Pidgeon & Henwood, 1998). Therefore, transcription could take as much as 50 hours.

### *Power Calculation*

None required due to qualitative nature of this piece of work. Purposive iterative sampling (Willig, 2001) will be used which will have implications for the number of children taking part in the study.

### *Data Analysis*

Interpretative Phenomenological Analysis (IPA) has been selected to best answer the research question. IPA is "an attempt to unravel the meanings contained in ...

accounts through a process of interpretative engagement with the texts and transcripts" (Smith, 1996, p.189) which results in an greater understanding of the essence of a phenomena based upon individual's experiences (Willig, 2001). Such a phenomenological perspective is particularly relevant to this study as this methodology "focuses upon the content of consciousness and the individual's experience of the world" (Willig, 2001, p.52) which meets the study's aims. While having the aim of gaining an understanding of the world as it is perceived by participants IPA also acknowledges the interaction between the participant and researcher in the research process.

IPA requires that subordinate and overarching themes are identified within and across transcripts through a process of reading and re-reading texts. Links are forged between the identified themes and these can then be viewed alongside information drawn from existing theories to gain an understanding of how social disinhibition is perceived and experienced by the children in the study (Smith, 1996).

Interviews will be transcribed as soon as they have been conducted and analysis of each will start soon thereafter. In this way the transcripts of each interview will inform the collection of further data and their subsequent analysis (Flowers, Smith, Sheeran & Beail, 1997). This allows for the use of an iterative and purposive sampling method.

A proportion of the transcripts, minimum of 20% of children taking part, will be analysed by another researcher who uses IPA to ensure that similar themes are being uncovered and to allow for discussion of emerging themes.



I will undoubtedly need to reflect upon the interaction between myself and the children during interviews. This will be influenced by any socially disinhibited behaviours displayed by the children themselves and my values and beliefs. This would need to be acknowledged during the analysis of the interview material, as my interactions with the children would have the potential to bias my interpretation of the interview data. To facilitate the use of this additional data, comprehensive notes will be taken immediately after the interview about my impression of the child's behaviour towards me and my response to this. Such reflexivity is appropriate to include in the analysis as an appreciation of the participant-researcher interaction is particular strength of IPA as this method explicitly acknowledges its' influence in the analytic process (Reid, Flowers & Larkin, 2005).

Analysis of the data will be supported by Dr Barbara Duncan, Chartered Health Psychologist at Glasgow Caledonian University, who has extensive experience in the use of IPA.

### *Practical Applications*

Zeanah, Smyke and Dumitrescu (2002) state that interventions to reduce indiscriminate behaviour are in need of exploration. Thus, additional information on the reasoning underlying the socially disinhibited interactions of children would offer a clearer understanding of the cognitions and beliefs underlying this style of interaction. While clinicians have attempted to place their own understanding onto this behaviour it will be more illuminative, and more valid, to gain such information

from the children themselves. Such information would undoubtedly assist in the search for an effective intervention.

### *Timescale*

<b>2006</b>	
November	Carry out focus groups Piloting of interview schedule Start recruitment + book first interviews Start interviewing, transcription and analysis - Aim to start interviewing with minimum 2 children
December	Continue interviewing, transcription and analysis - Aim to have recruited and started interviewing 8 children - Aim to transcribe each interview within 2 weeks of it taking place - Aim to analyse 1 <sup>st</sup> 2 interviews by end December
<b>2007</b>	
January-February	Complete interviewing - Aim to complete recruitment of 10 children and to have conducted all 1 <sup>st</sup> meetings and minimum 6 interviews Continue with transcription and analysis as interviews are completed
March–April	Finish analysis and begin write-up
May-June	Complete write-up
July	Submission of research paper and systematic review

### **Ethical Approval**

Consent for participation would be required from the children involved in the study and their parents or carers. Approval will also be sought from the Local Research Ethics Committee. Written consent for participation and recording and transcribing of interviews will be sought from both parents/carers and children.

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## Addendum: Changes to protocol

### *Participants and Recruitment*

All young people opting into the study were offered the opportunity to take part in an interview. Selection did not take place in order to ensure a range of indiscriminate friendliness or to focus on older participants as proposed. This was due to a late start in the recruitment process due to delays in gaining ethical approval for the study and a slow recruitment response. However, as can be seen by table 4.1 in chapter 4, a range of indiscriminate friendliness scores and ages were reflected in the sample recruited.

### *Measures*

The Relationship Problems Questionnaire was completed by guardians as outlined in the proposal. However, the four items focusing on indiscriminately friendly behaviour were focused on instead of the total. This was considered to be more appropriate to the study aim. These items can be found in appendix 4.13.

While scenarios were used during interviews these were presented verbally without any picture to support this. Thus, provision of an outline of a scenario allowed the young people to interpret this themselves without being constrained by additional information which a drawing may have imposed upon them. This was considered to an approach more appropriate to Interpretative Phenomenological Analysis within which young people bring along their meaning of the world as opposed with minimal structure being provided by the interviewer (Smith, 1996).

### *Procedure*

Interviews lasted one Hour rather than the 30 minutes outlined in the proposal. The young people interviewed were difficult to interact with due to the amount of control which they used within the interview relationship. As a result, a longer window of time was employed to give them the opportunity to share their experiences and the meaning they associated with these. This length of interview was consented by guardians and young people prior to the interviews taking place. This doubled amount of time required for transcription.

### *Time Scale*

There was a delay in gaining ethical approval due to two reasons; i - request for clarification of procedure, ii - incorrect information being provided to the lead researcher regarding a change in the title of Ethics Committee applied to. Ethical approval was awarded 15<sup>th</sup> November 2006 (see appendix 4.2). As a result recruitment did not start until this point which delayed interview dates. Despite concerted recruitment efforts with clinicians in Glasgow, Adoption UK and other adoption agencies there was a slow opt-in rate to the study and interviewing continued until June 2007.

## CHAPTER 4: MAJOR RESEARCH PROJECT

### A Qualitative Exploration of Children's Understanding of Indiscriminate Friendliness

Prepared in accordance with requirements for submission to *Clinical Child Psychology and Psychiatry* (see Appendix 4.1)

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Clinical Psychology (D.Clin. Psy)*



## Abstract

Eight young people (aged 9-14) took part in interviews about indiscriminately friendly behaviour. The majority of the sample had a history of maltreatment and placements within foster and care settings. Clinicians and guardians identified these young people as indiscriminately friendly, which was supported by data provided by the Relationships Problems Questionnaire. Interview transcripts were analysed using Interpretative Phenomenological Analysis, a phenomenological qualitative methodology that is gaining growing acclaim within the field of clinical psychology. Emergent themes were drawn from interview data which highlighted the young people's experiences of rejection and feelings of insecurity within their social interactions. While being aware of the risks associated with speaking to strangers and the efforts of adults attempting to protect them from the potential danger associated with indiscriminate friendliness this group of young people demonstrated a trust of new people and a craving for kindness from others. Through their descriptions of social interactions, and the experience of the interviewer during her interactions with these young people, there was a strong appreciation of the control they exert upon others during social contact. These findings offer clinicians an insight into the social interactions of this vulnerable group of children.

**KEYWORDS:** *children, indiscriminate friendliness, reactive attachment disorder, understanding*

Social development is a key task for children and adolescents. Difficulties in this domain can have knock-on effects in cognitive development and psychological well-being. Indiscriminate friendliness could be perceived as being an advantage for children as they present as fearless in interactions with others. However, a deeper consideration of the interactions of indiscriminately friendly children illuminates overwhelming concerns about the welfare and futures of these children.

#### What is indiscriminate friendliness?

Zeanah, Smyke and Dumitrescu (2002) define indiscriminate friendliness<sup>4</sup> as “a pattern of wandering off without checking back, failing to exhibit reticence with unfamiliar adults, and being willing to go off with a stranger”. This could be in a context of having a preferred attachment figure or without a such a figure. Further, this style of interaction is typified by friendliness towards new adults and approaching strangers (Chisholm, 1995) in addition to a lack of differentiation among adults (O'Connor, Rutter, English and the Romanian Adoptees Study Team, 2000).

The Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, 2000) includes social disinhibition within the diagnostic criteria for the disinhibited subtype of Reactive Attachment Disorder where they describe it as “being overly familiar with or seeking comfort from an unfamiliar adult caregiver” (p. 129, APA, 2000). This diagnosis is most commonly made for children who have been maltreated and those who have been institutionalised (Boris, Zeanah & Work Group on Quality Issues, 2005).

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<sup>4</sup> Social disinhibition is an equivalent term used by some authors.

*Which children tend to be indiscriminately friendly?*

Research to date has looked at social disinhibition in children reared in institutions and children who have been fostered, adopted, neglected or abused (Albus & Dozier, 1999, Borris, Zeanah, Larrieu, Scheeringa & Heller, 1998; Borris, Wheeler, Heller & Zeanah, 2000). Tizard's work has found that the greatest levels of indiscriminately social behaviour is seen in children who have been institutionalised (Hodges & Tizard, 1989; Tizard & Rees, 1975). Similarly, Smyke, Dumitrescu and Zeanah (2002) found that the majority of children from institutions in their study were socially disinhibited whereas only 12% of similar-age contrast children who had never lived in an institution behaved in this way.

Indiscriminate friendliness is a persistent social difficulty for these children (Zeanah, Smyke & Dumitrescu, 2002). They identified what Chisholm termed 'indiscriminate friendliness' in children at a median of 11 months and 39 months post-adoption. Although security of attachment between child and primary caregiver significantly increased between these time points indiscriminate friendliness did not reduce (Chisholm, 1998).

Chisholm's discovery of indiscriminate friendliness within the context of a secure attachment has been supported by Marvin and O'Connor (1999). They found that at 6 years old a number of children adopted out of Romania continued to be classified as indiscriminately friendly despite being securely attached to their adoptive parents. Chisholm (1998) concluded "that indiscriminate behaviour is not a sign of disordered attachment, instead, she suggested that it may well be an adaptive

behaviour in the institutional setting and selectively reinforced after adoption” (Zeanah et al., 2002, p.983).

### *Long-term consequences*

Disinhibited behaviour endures into early adulthood (Wolkind, 1974). When Tizard followed up children who had lived in an institution for their first 2 years at 16 years their ‘overfriendly’ behaviour had lessened, yet there was evidence of significant peer relational problems (Hodges & Tizard, 1989). There were more adult-orientated, had peer relationships problems, did not have a best friend, did not turn to peers for support and were not selective in choosing friends.

### *Proposed explanations of social disinhibition*

The most characteristic feature of children reared in institutions is a lack of selectivity in social approaches and in comfort seeking (Chisholm, 1998; O’Connor et al., 2000). Roy, Rutter and Pickles (2004) perceive such difficulties as a deficit in perception of social cues and in the appreciation of social boundaries rather than indiscriminate friendliness ‘per se’. “The children seek social contact but do so in ways that are relatively unresponsive to social conventions and which are relatively non-differentiating with respect to the people to whom social overtures are made, and from who social advances are accepted” (Roy et al., 2004, p.871). Alternatively, the ‘brashness’ of approaching any adult may be motivated by a craving for contact and to have one’s needs met (Smyke, et al., 2002).

## Summary and Aim

There is a growing body of research and theories in relation to indiscriminate friendliness. However, we do not know what life is like from the perspective of a socially disinhibited child, we do not have information about how they perceive their behaviour and the motivations they ascribe to this. Thus, this study aims to gather information about experiences of social disinhibition from children who are socially disinhibited themselves through the use of a semi-structured interview. This information was analysed using Interpretative Phenomenological Analysis with the aim of gaining an understanding of the phenomena of indiscriminate friendliness from the perspective of the children who behave in this way.

## Method

### Design

This study aimed to explore experiences of indiscriminate friendliness and the meaning young people ascribed to these. Interviews were used to gain information which was analysed using Interpretative Phenomenological Analysis (Smith, 1996). Quantitative measures were included to affirm the perceived presence of indiscriminate friendliness reported by referring clinicians and guardians.

### Rationale for Interpretative Phenomenological Analysis methodology

Qualitative methods are best placed to analyse data exploring individual meaning. Interpretative Phenomenological Analysis was chosen as it aims to capture and explore the experiences of the individual without testing hypotheses or making assumptions about the meaning of the topic being investigated (Reid, Flowers & Larkin, 2005). The aim of accessing underlying meaning and cognitions is central to

Interpretative Phenomenological Analysis. This methodology also acknowledges the interaction between the participant and researcher in the research process. This is crucial as the interpretation of one person's report by another individual involves an interaction and possesses a degree of subjectivity. Further, Interpretative Phenomenological Analysis is a critical realist ontology which potentially limits the tension between using quantitative questionnaires and a phenomenological approach (Smith, 1996). Such a combination would be problematic were Discourse Analysis employed.

Grounded theory involves the sampling of large numbers of participants in order to gain complete theoretical saturation (Pidgeon & Henwood, 1996). This would not have been practicable within the time constraints around this study and neither would the numbers of participants required have been accessible. Discourse Analysis focuses on the use of language and does not make links between this and real world behaviour and thought (Smith, Jarman & Osborn, 1999) whereas Interpretative Phenomenological Analysis does make such links.

#### Participants and recruitment method

Smith, Jarman and Osborne (1999) recommend 10 participants as the higher end of the desired sample size for Interpretative Phenomenological Analysis. Nine children aged nine to fifteen years of age, with a mean age of 11 years 5 months, took part in this study. Clinicians working within Child and Adolescent Mental Health teams identified indiscriminately friendly children within Glasgow (see Appendix 4.4). Further, members of Adoption UK- Scotland<sup>5</sup> were contacted (see Appendix 4.5)

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<sup>5</sup> Adoption UK is a charity offering support information and advice to adoptive families before, during and after the adoption process.

offering adoptive parents the opportunity for their children to take part. Each interested family received a recruitment pack (see Appendix 4.6-4-11). Guardians and children 12 years and over were asked for written consent while verbal assent was required from younger children.

### Measures

Three questionnaires were completed prior to the interview. The Relationship Problems Questionnaire (Minnis, Rabe-Hesketh & Wolkind, 2002) was completed by guardians. This 18-item checklist assesses the attachment disorder behaviours of the inhibited and disinhibited subtypes of Reactive Attachment Disorder. Minnis and colleagues (2002) report an internal consistency (Cronbach  $\alpha$ ) of 0.85. The four items focusing upon indiscriminately friendly behaviours were summed to serve as a screen for such behaviours (see appendix 4.13) resulting in scores ranging from 0 to 12.

Guardians also completed the Strengths and Difficulties Questionnaire (Goodman, 1999) to provide an overview of emotional, conduct, hyperactivity difficulties and an indicator of social functioning. This is a widely used 27-item screening tool is measured on a 3-point Likert scale. Children completed the children's self-report version of this questionnaire. A recent review by Vostanis (2006) concluded that this questionnaire has achieved a significant degree of validity and reliability in its' parent and child formats within both clinical and research settings. The self-report format has also gained indication of sufficient reliability with children aged 7 and above (Mellor, 2004; Muris, Meesters, Eijkelenboom & Vincken, 2004).

## Procedure

The Primary Care, Community and Mental Health Research Ethics Committee with Greater Glasgow and Clyde NHS (see Appendix 4.2) granted ethical approval for this study. Introductory meetings and interviews took place in GP surgeries or Child and Adolescent Mental Health Service clinics familiar to the young person. Introductory meetings gave participants an opportunity to ask any questions about the study and to enable them to meet myself<sup>6</sup> prior to the interview. Young people and guardians completed consent forms for the interview to be recorded, transcribed and for subsequent findings to be used in potential publications (see appendix 4.12). Interviews were transcribed shortly after they took place allowing transcripts of each interview to inform the collection subsequent interviews and their subsequent analysis (Flowers, Smith, Sheeran & Beail, 1997).

### *Interview Procedure*

Interviews, lasting approximately one hour, took place one or two weeks following the introductory meeting at the same location. Three participants attended for two interviews. The first participant took part in two interviews as it became apparent after her first interview that the schedule required adapting. A second interview was conducted following adaptation (see below). The second participant took part in two interviews as her degree of control during the first interview inhibited the collection of sufficient information. Two 30 minutes interviews were planned for participant eight due to his concentration difficulties.

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<sup>6</sup> The author writes in the first person at points throughout this paper due the importance of their role within the interview process. This is appropriate in the use of qualitative methodology and also in light of the 5<sup>th</sup> Edition of the American Psychological Association's Style Rules (2001) which advocates the use of active voice over the passive voice and using personal pronouns when authors are referred to.



My reflections on interactions with each participant were noted after each interview. It was important to reflect upon these interactions as they had the potential to influence interpretation of the interview data while reflection upon these interactions offered me an insight into participants' styles of interacting with unknown adults. Such reflexivity is appropriate to include in the analysis as an appreciation of the participant-researcher interaction is particular strength of IPA as this method explicitly acknowledges its' influence in the analytic process (Reid, Flowers & Larkin, 2005).

### *Interview Schedule*

The author constructed a semi-structured interview schedule with reference to the existing literature on social disinhibition. This was piloted with two children without reported indiscriminate friendliness. According to the standard format employed within Interpretative Phenomenological Analysis methodology the schedule consisted of open questions (Smith, 1995). However, after interviewing the first participant it was found that the use of abstract open questions were difficult for these young people to interpret. Therefore, following consideration of these difficulties the questions were adapted to become more direct and concrete to make the questions intelligible to the participants. This enabled them to move on from the focus of friends to wider friendliness which had limited the information gained in the first interview. The adapted interview schedule is in appendix 4.14.

Further, two generic indiscriminate friendliness scenarios were generated from focus groups of clinicians and adoptive parent-support groups (see appendix 4.15). These ecologically valid scenarios provided stimulus material to be discussed with children

during interviews if they were unable to share their own experiences. These were employed in three interviews. Crouch and Wright (2004) also used a short scenario when encouraging young people to speak about self-harm within their Interpretative Phenomenological Analysis study while Barter and Reynold (2000) describe a number of qualitative studies which incorporated vignettes.

Drawing materials were used to facilitate discussion in four interviews. Asking younger participants to draw a time when they had been friendly provided a helpful introduction into the topic for some participants who had difficulty staying focused on the topic. Indeed, Mauthner (1997) notes that drawing can provide a good introduction to interview topics for younger children.

### *Analysis*

IPA identifies subordinate and overarching themes within and across transcripts through a process of reading and re-reading texts (Smith, 1996). Transcripts were analysed according to the method outlined by Smith, Jarman and Osborn (1999). Following transcription each transcript was read repeatedly and points of interest were noted in the left margin. Notes included summarising, making connections and preliminary interpretations. Exploratory coding was given in the right margin. After this process had been carried out for the first interview all emerging theme titles were considered and connections sought between these. The same process was carried out with each transcript building upon themes already developed. After repeating this process for each transcript all emergent theme titles were considered together with the aim of grouping these into clusters with each having a superordinate theme and potentially two or three subordinate themes.

Tables of quotes from across all interviews were constructed for each theme. This allowed for checking that the themes were supported verbatim within the texts and that the preliminary themes were the most useful way to organise the information. Several rounds of re-analysis was required to identify themes representing a coherent story of the information gathered in order to reach an end-point providing the richest representation of the transcripts. An example of a quote table for a theme is provided in appendix 4.16.

All transcripts were read by a researcher familiar with the topic area to check for content validity of themes. Additionally, four of the transcripts were analysed by a researcher experienced in the use of Interpretative Phenomenological Analysis to ensure that similar themes were being uncovered and to allow for discussion of emerging themes.

## Results

### Characteristics of sample

Nine young people (9-14 years) were recruited into the study. Each child was given a gender appropriate pseudonym. Their age, abuse and care history along with questionnaire data are presented in Table 4.1. Seven of the children had a confirmed history of abuse or neglect, one was suspected to have had such experiences and one child did not have any maltreatment history. Two had diagnoses of Reactive Attachment Disorder, two had diagnoses of Fetal Alcohol Syndrome and four had diagnoses of Attention Deficit Disorder. Four of the children were adopted – one of whom was in residential care at time of the interview, another was in residential care with some foster care provision, three were living with birth parents and one with

another family member. Three young people were recruited through Adoption UK and the remainder through Child and Adolescent Mental Health services. Unfortunately, Matt was not interviewed as contact was lost with the family following the introductory meeting.

#### Questionnaire Data

The four questions from the Relationship Questionnaire gave scores ranging from 5 to 12, with three young people scoring the maximum. The presence of positive scores on these questions supported the referring clinicians' and parents' verbal report of indiscriminate friendliness.

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Insert Table 4.1 about here

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The Strengths and Difficulties Questionnaire reported a high rate of difficulties for all participants in all areas except prosocial behaviour which was close to normal range (see Table 4.1). While there was a high degree of accord between parent and child report on this questionnaire the classification indicating the greater degree of difficulties is given where these differed. The difficulties in peer relationship subscale is the most relevant which classified all but one young person as having a very high rate of difficulties in this area. All young people scored within the very high category for total difficulties score.

#### Reflections upon interviews

I had a sense that tension existed between some of the young people and their parents regarding indiscriminate friendliness. This made it a difficult topic to tackle which sometimes resulted in the young people appearing to take a defensive strategy

and denying any indiscriminate friendliness. Hyperactivity difficulties were also apparent with a number of the young people for whom it was difficult to speak for a length of time and challenging to remain focused on one topic. It was difficult to ascertain whether a difficulty answering some of my questions was due to these issues or to a lack of insight. Introductory meetings with the young people had a feeling of my being tested by their use of control. This is explored in detailed within the control theme. Except for efforts to control the interview, there were not other signs of anxiety within the interview sessions.

### Emergent themes

Five emergent themes were identified within the interview transcripts; concept of friendship, rejection, insecurity within relationships, adults' protective responses and kindness. While these are presented as separate themes, a full appreciation of each can only be achieved through an understanding of the others and their connections. Themes suggest that social interactions are problematic for these young people.

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Insert Table 4.2 and Figure 1 about here

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#### *Emergent Theme One: Concept of friendship*

Descriptions of friendships given by these young people lacked the boundaries normally in place according to others' age, role and degrees of intimacy. Thus, this theme had connections with the protective responses of adults theme which highlights the issues around strangers

*Low threshold for friendship.* The typical response to an enquiry about who the participants' friends were was 'everyone' or a long list of names. This suggested

that there is a low threshold of interaction and qualities for people to become friends of these young people. Arun (13 yrs, birth parent)<sup>7</sup> provided an illustrative quote.

Arun: I can be anybody's pal.

And Samantha (10 yrs, relative) claimed that I was one of her friends.

Samantha: Yes, because I've tested you [JB] with my whys, you've lasted really long and you've proved yourself trustworthy.

*Lack of discrimination.* Peers and adults were considered similar types of friends with little if any, discrimination between them.

Samantha: Well, Alison [peer] is my best best friend and you are .....Gareth Timmins [peer] is a really good friend but Alison is my best best friend. So you are like Gareth, a really good friend.  
 Julie: And how about Miss McMurray [teacher]?  
 Samantha: Ummm, same as Gareth.  
 Julie: So you're just as good friends with Miss McMurray and Gareth and me?  
 Samantha: Um hum.  
 Julie: And where does Mr Garry [teacher] fit?  
 Samantha: With Alison.  
 Julie: With Alison, he's a really really good friend. And what's the difference with these piles of really really good friends? You've got Mr Garry and Alison here and all these other people here. What separates them out?  
 Samantha: People who are like Gareth are people that I can trust for sure and that are good friends, and people that are with Alison are people that I know for a fact that I can definitely trust and they're really really good friends.

This was illustrated by Samantha (10 yrs, relative)<sup>8</sup> who categorised friends into two groups; good friends and really good friends. This placed peers and teachers within the same categories of friendship which suggested that these friendships may lack the depth and companionship that may typify many young people's friendships.

Julie: Well you and me have met two times now, would you say I'm your friend or I'm something else?...I'm just trying to understand this, I'm just wondering.  
 Samantha: A f.f.f.friend.  
 Julie: I'm a friend. Am I the same sort of friend as all your different groups of friends?  
 Samantha: Close, close.  
 Julie: So, how are we the same and how are we different?  
 Samantha: You and Alison [peer].

<sup>7</sup> Age and care situation of each child is given along with each quote to provide a context.

<sup>8</sup> Peers and adults referred to in quotes has been given gender appropriate pseudonyms.

Julie: Yes.  
 Samantha: Well, Alison is my best best friend and you are .....Gareth Timmins [peer] is a really good friend but Alison is my best best friend. So you are like Gareth, a really good friend.  
 Julie: And how about Miss McMurray [teacher]?  
 Samantha: Ummm, same as Gareth.  
 Julie: So you're just as good friends with Miss McMurray and Gareth and me?  
 Samantha: Um hum.

Samantha's classification of friends was explored in more detail locating me in contrast to her other friends. I was considered trusted and therefore as good a friend as peers and teachers she had known for years.

This lack of distinction was apparent for the majority of young people interviewed with the one exception of Claire (12 yrs, adopted). She made clear distinctions between adult and peers. She did not report any friendliness with adults and was able to make clear distinctions between peers whom she was friendly with and those whom she described as her best friends.

Claire: Because, like, they [best friends – peers] stand out from the rest. Like, we're never, like if you're down the other people just try to make you feel better but they don't really, but Claire [peer] always makes you kinda laugh. She doesn't do stupid stuff as much, but she'll be funny. And she'll tell you weird jokes that'll just make you burst out laughing. I just feel that like, they're like more nice to people than other people who just treat me as a friend.

### *Emergent Theme Two: Rejection*

All of the young people interviewed spoke about some experience of being excluded or bullying from peers. While this is a distinct theme there are clear associations with craving for kindness from others, the importance of trusting others and welcoming any friendly advances from others, regardless of age or role.

*Exclusion from peer friendships.* Exploration of the nature of friendships revealed that this group of children have limited friendship memberships and that peers frequently reject advances made by these children. Jennie (14 yrs, adopted) spoke about experiences of being bullied over a number of years.

Jennie: I trusted somebody in S1, well, this girl called Shona [peer] and there's a boy called Luke [peer], and I trusted them and they said that they wanted to take me down the street for my lunch and I got myself beaten up.

Julie: Huh! Oh my goodness me!

Jennie: Oh yeah, try cigarette burns to the back of the neck, it's painful.

Julie: You are kidding me?

Jennie: I'm not.

Julie: Oh Jennie, that's awful.

Jennie: Doesn't bother me now.

Julie: Not good at the time tho?

Jennie: Not half as bad as being bullied at every single school I went to.

Other young people emphasised the importance of being included and personal experience of exclusion. While Jody (9 yrs, adopted) spoke of being left out within her current friendship group Samantha's (10 yrs, birth relative) quote suggests a sense of loneliness and perceived bullying from the majority of her peers.

Jody: I don't think it's fair if Anna whispers to somebody that's my friend and she doesn't tell me and neither does my friend. If it's not bad then she can say it out. If it is, she doesn't want to say it.

Samantha: I've only really got one friend and all the others bully me.

Jennie (14yrs, adopted) and Elizabeth (14 yrs, adopted) emphasised the importance of inclusion in the role of a good friend and in being friendly towards these people. In particular, Elizabeth expresses great empathy for others and not wanting others to feel as lonely as she had been made to feel.

Julie: What would you say the most important thing is about being a good friend?

Jennie: Being there for somebody ...and not excluding somebody just because of who they are or where they stay or what they think's right.

Elizabeth: Being friendly towards them [peers] would be like talking to them, making sure they feel comfortable, not feel like outside, feel like part of the group.

*Adults safer than peers.* There was a sense from the girls within the sample that adults are safer than peers. In discussion of a scenario where a young girl chose to sit with a stranger at a school play rather than with peers sitting nearby Jody (10 yrs, adopted) said that adults were safer.



Jody: Well I think probably, that she wanted to talk to adults because she'd feel safer 'cos some of these girls might hit her.

On discussing another scenario with Hayley (9yrs, birth parent) she told me that the girl would prefer to speak to an adult stranger rather than an unknown child because the children aren't nice to her.

Julie: What are the reasons for children being friendly with adults instead of children?

Hayley: Because the adults are the mother's friends and the children are mean....Because the adults are friendly and the children are mean.

Such comments were not apparent within the boy's scripts who described peers as being safer than were adults.

### *Emergent Theme Three: Insecurity within relationships*

Insecurity within social relationships was a focal theme across the transcripts. The importance of trust within relationships and ways to test this were made explicit. However, the need to control social interactions with others became clear only through their interactions with myself in the interview situation.

*Importance of trust.* Every young person interviewed identified the need for trust as an important factor in their relationships with both adults and peers. This was crucial within friendships where uncertainty about friends keeping information given in confidence was a concern. Arun (13, birth parent) highlighted this issue.

Arun Cos you dinnae want anybody knowing about your business and .....if they [peers] tell someone else they wouldn't be your pal because they broke the promise.

The young people reported having been let down by friends and having had their confidences broken. This links to experience of mistrusted and inconsistent adults.

Claire (12 yrs, adopted) provides an example of this when speaking about her experiences of meeting new peers and teachers at secondary school.

Claire                      Different, like some people are nice, some people are not that nice. Like, you just need to watch out for the people that aren't that nice. They pretend they're nice and then when you get to know them they're not.

There was a suggestion that adults were more trusted than peers. It is possible that this links with the peer rejection reported and the perception that adults are safer than are peers. Elizabeth (14, adopted) contrasts her trust of peers and teachers.

Elizabeth:                'Cos I can sometimes, sometimes it's easier to trust older people than it is to trust people my age...I don't know. There's like, more like a couple of teachers I wouldn't trust and there's only like a couple of kids I would trust. so I think it might be about age.

*Checking and testing strangers.* The importance of trust and the rejection experienced by these young people has resulted in a need to test new adults and peers. While they were often happy to interact with new adults they used a number of strategies to test these adults. When I asked Samantha if there were any people she could not be friends with Samantha (10 yrs, birth family) told me about a particular strategy which new adults must pass. Indeed, when I first met with Samantha she tried this out on me.

Samantha:                Just say why all the time to see how long they can last.  
 Julie:                      Yeah, and then what do you think of them after that?  
 Samantha:                Well, I think.....the longer an adult can stand me saying why, the longer, like, ....it's hard to explain again.  
 Julie:                      Keep going.  
 Samantha:                The longer, like, the longer an adult can stand me saying why the better a friend they are.  
 Julie:                      Why is that?  
 Samantha:                ... Because friends always listen to you for really really long, well, you know what I mean. And if someone just says right, that's it after a couple of whys then they're not really a friend.

In addition to this questioning strategy, she also said that strangers need to prove themselves by knowing someone she knows to be ‘passed’ as being safe. Ryan (13 yrs, residential care) said that he always checks out new people on meeting them.

Julie	What’s the best strategy, the best way you have of checking people out?
Ryan	Sometimes I’ll look on the computer.
Julie	...Ok. What other ideas do you have for checking people out, what else do you normally do?
Ryan	Data files.
Julie	Ok, what do you mean by data files?
Ryan	I mean data and what happened to them and all that....I check out their data first...If Suzanne and Colin [foster parents] didn’t know them then.....em....I’d check their data. And if they had data that wasn’t good then Suzanne would chuck them.
Julie	So what sort of data would it be that wasn’t good?
Ryan	If they’d committed crimes and all that then they’d be chuckled.

On talking about new peers and adults Elizabeth (14 yrs, adopted) described how she watches them before she speaks to them and gave an example of gathering information on new teachers before trusting them.

Elizabeth:	Say it’s the first day of having a teacher, I wouldn’t actually say anything to them. I’d just sit back and watch what everybody says, what everybody else says to them and what they say back and what they react to and what they won’t react to.
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However, this strategy was more difficult to use with new peers than with new adults. Arun (13 yrs, birth parent) agreed with Elizabeth in it taking a length of time to get to know new peers, although he was more concerned about their potential for getting into trouble than their trustworthiness.

Elizabeth:	Yeah, ‘cos it’s a whole lot harder to suss other kids out...It takes a whole lot longer. Because, they, most of them won’t talk that much, well, some of them might, some of them might be like my sister....‘Cos if I don’t know what they like or doesn’t like or....I just can’t find out anything about them.
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While they spoke about people requiring assessment before they could be welcomed into their lives some young people thought that certain adults did not require such checking due to their trusted role. Arun (13 yrs, birth parent) felt that teachers could

to be trusted as any breach of this would be acted on by the authorities, hence protecting him.

Arun: Well a teacher, I'd trust them. 'Cos if they done anything to anybody in the class they would get batted out of school.

While Jennie (14 yrs, adopted) emphasised that she was protected from being harmed by some adults she also emphasised a requirement for her to trust care staff.

Jennie: There's a difference between [residential care] staff because I know that they can't do anything to me and I can trust them. I've got to haven't I because otherwise I'd get no-where in life.

*Taking control.* Throughout the interviews it became apparent that the young people regularly took, or attempted to take, control of the interview by questioning myself, changing the topic of conversation or even the activity. I felt that Jody (9 yrs, adopted) was controlling within her interviews.

Jody: Now. If you would like to ask any questions Julie ask them now.

Jody took the role of the interviewer by directing the questioning and the activity within the room. For example, she introduced a written conversation, acting out a scenario, and asked me questions on a scenario she presented to me. Hayley (9 yrs, adopted) was also particularly controlling of the interview. In this example I had said that some children like to talk to adults and had asked her what she thought about that.

Hayley: Which children?  
 Julie: I've been talking to other children.  
 Hayley: What did they say?  
 Julie: I can't tell you.  
 Hayley: Oh please.  
 Julie: Well, the thing is, if I tell you what they said then...  
 Hayley: I won't copy them. I promise.  
 Julie: Yeah, I know you wouldn't copy them but it's confidential, it's private to them. Like, I won't tell other children what you've told me.  
 Hayley: Why?  
 Julie: I won't tell other children what you've told me.

Hayley: Well, maybe you can just tell me. If you just tell me what they said I won't tell anyone else.  
Julie: I can't do that.

*Emergent Theme Four: Adult's protective response*

Participants spoke about adults' attempts to highlight the dangers of talking to strangers and the young people report awareness of 'stranger danger' themselves. However, this did not necessarily fit with their reports of social interaction suggesting that this knowledge does not follow through to behaviour.

*Prevention of child-adult interaction.* Several young people told me that their relatives actually prevented them from interacting with strangers when they were out. For some this involved warnings not to speak with strangers when they were going out (Arun, 13 yrs, birth parent).

Arun: As soon as I say I'm gonna disappear he [my brother] says you no better talk to strangers.  
Julie: Does he? How come he said that?  
Arun: Don't know. He cares about us.....Anytime I go out to play with all my pals and that he says "don't talk to strangers".

While others spoke about interventions which adults placed upon them when they were out (Hayley, 9 yrs, birth parent).

Hayley: Because when I'm with my Gran she shouts at them to go away.  
Julie: Does she? She doesn't let you talk to people?  
Hayley: Only the people who I know.

Hayley went on to speak of the consequences put in place if she spoke to strangers.

Julie: So what would your mum say if you were friendly with adults?  
Hayley: No. Nooooo. No way!  
Julie: So what happens if you're friendly with adults?  
Hayley: I get a smacked bum.

*Instilling 'stranger danger' awareness.* Young people interviewed reported explicit awareness of 'stranger danger'. Jennie (14 yrs, adopted) made this explicit to me.

Jennie: Don't talk to strangers. Didn't you ever get told that by your mummy and daddy?

There was a feeling that they had heard the message from parental figures. However, the indiscriminate friendliness they described and the ease with which they come to trust new adults caused some concern for their ability to apply these safety rules. Ryan's (10 yrs, residential care) description of my not being a stranger illustrates this.

Julie: Am I a stranger?  
Ryan: No. You're not a stranger 'cos I know you now.  
Julie: OK. Was I a stranger last week?  
Ryan: No. You're only a stranger if no-one knows you here, and like, Claire [carer] knew you because she knew you weren't a stranger....and she knew you weren't a stranger...

To place this in context, I had had one telephone conversation with his carer prior to meeting Ryan. Further, despite his assertion that I was no longer a stranger and by implication trusted, he did not carry out the checking he had described to me (see checking theme). Despite efforts to instil some wariness for new adults this does not appear to be applied within day-to-day life.

#### *Emergent Theme Five: Kindness*

All young people interviewed placed an importance on kindness within their friendliness towards others and as a prized quality among friends.

*Kindness offered to others.* When asked to define friendliness the most frequent answer was kindness and helping others. There was a huge range of helping

behaviour reported by the interviewees including helping teachers, neighbours, siblings, disabled people and those disadvantaged within society. Jody (9yrs, adopted) expressed pride in her kindness towards others. Such acts were her expressions of friendliness towards others. In this quote she presents herself as confident in social interactions and as being in control of this.

Jody: They just em, like, em, friendly people like me they just, sort of like, you know, em, they...help people when they fall over. They're very kind and generous.

When I asked Arun (13 yrs, birth parent) about times when he had been friendly he spoke about the previous week when he had helped an elderly neighbour and Ryan (14 yrs, residential care) gave an example of being friendly to a teacher.

Arun: Been helping with the gardening and that. Doin' weeding and they can't get back up, and I'll say "I'll do that for you".

Ryan: if she's trying to print something and then it's not coming out then I just give her a hand because I'm quite good with computers.

Helping was at the core of their understanding of friendly behaviour. Some young people were able to explain their kind behaviour. For Arun this was about keeping out of trouble while Samantha (10 yrs, birth family) framed this as a form of reward for others who had been kind to her.

Arun: Just like doin' it. Keeps me out of trouble.

Samantha: He's a nice teacher.

However, Elizabeth's (14 yrs, adopted) motivation for kindness towards others feels as if it links in more closely to empathy towards others who might be excluded.

Elizabeth: To me it means, maybe, you get on with them, talking to somebody like...for example, see if there was like somebody new. Being friendly towards them would be like talking to them, making sure they feel comfortable, not feel like outside, feel like part of the group. Em...well generally, just being nice.

*Kindness received from others.* Kindness formed the definition of a friend.

Seeking such responses from others appeared to be the goal of their own friendliness and indicated a strong connection with others as well as a sense of acceptance Jennie (14 yrs, adopted) emphasised the importance of caring and kind friends with whom she could spend fun times.

Julie: What would you say a friend is?  
Jennie: Somebody that cares and that takes care of you, somebody to talk to you and you laugh with, someone that helps you.

Kindness was expressed in the form of support was emphasised by Samantha (10 yrs, birth family) and Claire (12 yrs, adopted). Yet, experience of rejection was also incorporated into the role of friends where Samantha focused upon friends not being bullies while Claire focused on their protective role against potential bullies.

Julie: What sort of people are your friends?  
Samantha: Well, I suppose that don't bully or push you around...and people that are always there for you and they don't blackmail you.

Claire: She's always there for you, like, if someone tries to bully you or something, she'll come in and say, "she's my pal don't say that".  
Julie: Ok.  
Claire: Because she's got big attitude, big time. Like if somebody makes fun of her pal right, she'll just go up to them and say "don't do that again".

## Discussion

### Study Summary

Children's understanding of indiscriminate friendliness was explored in this study. This was achieved through the interviewing of eight young people and analysis of their transcripts using Interpretative Phenomenological Analysis. The children were aged 9-14 years old and were recruited through child and adolescent mental health services and voluntary organisations. The majority of these young people had a



history of abuse or neglect and had contact with the care system in the form of adoption, foster or residential care placements. Further, the majority had received a diagnosis of Reactive Attachment Disorder, Attention Deficit Hyperactivity Disorder or Fetal Alcohol Syndrome. Questionnaire data indicated that these young people had difficulties with peer relationships and that they were indiscriminately friendly.

### Summary of Themes

Five emergent themes were identified. While each stands alone as a discrete theme they are best appreciated within the context they provide each other. An illustration of these links can be viewed in figure 4.1.

Experiences of rejection were identified as a central theme. Participants spoke about being bullied, excluded from peer groups and having few same-age friends. Indeed, peers were considered to be mean and untrustworthy. On the other hand, adults were perceived to be safer and less likely to reject them in comparison to peers. However, it should be noted that these children did report having friends, both other children and adults, which suggests an ability to initiate and maintain friendships. This supports research identifying the presence of such skills among maltreated children (Salzinger, Feldman, Ng-mak, Mojica and Stockhammer, 2001).

The theme of rejection within relationships links into the concept of friendship. The young people interviewed spoke about friendships in a way which indicated a lack of distinction between degrees of friendship. While a minority of participants spoke about best friends in comparison to acquaintances there was a strikingly low threshold for people to cross before they became good friends. This ties in with

Salzinger, Feldman, Hammer and Rosario's (1993) findings that maltreated children have difficulty differentiating supportive and unsupportive friends. There was also little distinction across age or role as regards who could and who could not be called a friend and who was appropriate to be friendly towards. This lack of discrimination and the welcoming of people into their friendship circle poses some concern as to the safety of these young people.

The protective response theme suggested that adults within these young people's lives are concerned about their welfare. Indeed, it is likely that the participants' perceptions of adults as being safer will have added to the concern expressed from people caring for these young children. Participants spoke about relatives and care staff making efforts to safeguard them through instilling in them an appreciation of 'stranger danger'. In addition, some young people were also prevented from speaking to unknown adults whilst others were punished if they spoke with strangers. It is clear from the interviews that the young people had heard the 'stranger danger' message and they were proud to recite this to myself. However, the majority of the sample failed to put this into action within the examples of meeting strangers which they recounted. This suggests that they have the knowledge but they have difficulty in putting this into practice.

The strength of the 'stranger danger' message and the rejection experienced by these young people may have been involved in the sense of insecurity communicated by their focus upon trust within relationships. Trust was a crucial quality required of friends and those considered inconsistent or likely to break confidences were not valued. Indeed, the majority of the young people had strategies which they employed

to ensure that new adults and peers were safe. However, whilst they told me of their specific strategies employed in assessing new people the lack of discrimination employed in admitting people into their friendships circle and the low threshold required to become a safe person did not reflect such diligence. While the young people may value trust and be aware of the 'stranger danger' message, it is not apparent that this knowledge comes into practice when they are interacting with others.

Another facet of the insecurity theme was participants' use of control. While this was not made explicit by the young people's speech it was apparent within their behaviour during interviews. The majority of interviews involved periods where the young person reversed our roles and took the part of the interviewer. It is proposed that this may function as a way of reclaiming a sense of security within the interaction.

Cassidy and colleagues (Cassidy & Marvin, 1988; Main & Cassidy, 1992) have also identified the use of controlling behaviour among young children. In particular, they discuss the use of controlling-caregiving behaviour which aims to protect the carer by excessive helpful, polite or cheerful behaviour. This style bears a significant resemblance to the kindness they offer to others and their use of control. Further, Cassidy and colleagues note that controlling-helpful behaviour is particularly prevalent among young children who have lost a close family member which is a description which could be applied to most children in this study. While attachment was not assessed in this study there are potential links with attachment theory. For example, controlling behaviour is sometimes seen in insecurely attached children as a result of internal working models developed during early attachment relationships.

Kagan (2004) hypothesises that this controlling behaviour is a response to a lack of care, or inconsistent care, in early attachment relationships.

The final theme, kindness, links with the concept of friendship, rejection and insecurity within relationship themes. All three of these themes could be considered to influence kindness through a desire for acceptance and friendship. This group of young people described themselves as being helpful and kind towards both peers and adults within their lives and treasuring any kindness shown towards them. This theme fits with hypotheses presented by Smyke, Dumitrescu and Zeanah (2002) regarding indiscriminate friendliness being an attempt to have needs met.

### Implications

These findings suggest that children perceived as indiscriminately friendly by the adults surrounding them are seeking friendship and acceptance in the best way they know how. Unfortunately, in their efforts to be accepted they report placing themselves in a vulnerable position due to their lack of discrimination with whom they are friendly in addition to the negative impact of peer rejection.

While it may appear to the observer that indiscriminately friendly children are impulsively interacting with others without thinking through their actions, these children actually put a great deal of thought into their social interactions. Unfortunately, they may be blinded by their goal of gaining kindness and friendship without an appreciation of the dangers which may be involved in such friendliness. This lack of awareness is despite apparent efforts from adults to safeguard these young people. The importance placed upon kindness could be a reaction to the

rejection experienced by these children. The majority of the young people interviewed no longer live with their birth parent suggesting that they have experienced rejection from the people whom they would most expect to provide care and acceptance. Unfortunately, young people's reports suggest that experiences of rejection have continued and their desire to relate to others and to be cared for continues to be a strong factor within their interactions. Indeed, it may be that this leads to others rejecting them as their desire to be accepted may be too strong for others to bear.

It is possible that the potential point at which to intervene to support the development of peer relationships is to focus upon the insecurity aspects which were strong drivers for friendliness among these young people. Promotion of trusting and supportive relationships outside of the primary caregiver should be supported where and whenever possible (Borris et al., 2005). This could aid in the development of a concept of trust and appropriate evaluation of this within friendships. However, when the maltreatment background of these young people is considered alongside the history of being cared for within foster and residential care, the presence of such insecurity and mistrust within relationships may be persistent. Further, an elaboration upon the concept of friendship and the differing gradations which different friends could fall into may be beneficial for these young people. This would contrast to the all or nothing concept of friendship which appears to be held by these young people.

However, some may consider that such interventions would pathologise these children. An alternative, and potentially more ambitious proposal, could be the promotion of a greater acceptance of these children and their particular interaction

styles within the wider community. This option would appreciate that this group of children respond to their individual life experiences in the most adaptive way possible. Encouraging their peers to be more accepting of children different to themselves could promote wider acceptance and the development of social skills on a wider scale.

### Limitations

These findings cannot be generalised across all young people displaying indiscriminately friendly behaviour due to the sample size. Further, it should also be noted that the wide age range and the developmental periods of these young people also poses problems as findings have been based upon the group of interviews as a whole rather than separating these by level of development or age. The gold standard would have been to recruit from a tighter developmental range (Trickett & McBride-Chang (1997). Yet, it can be argued that it was not appropriate to recruit different age groups of participants and compare these as Interpretative Phenomenological Analysis functions through the analysis of a group of heterogenous participants who can all be considered an expert on a specific topic (Reid et al., 2005). Further, difficulty in identifying indiscriminately friendly children would have made it impossible to recruit from a tighter age-range.

Participants had been criticised and punished for their indiscriminately friendly behaviour in the past. Thus, they may have limited the amount of information they were willing to share for fear of criticism from the interviewer and potential reporting of this back to guardians. Therefore, there is a possibility that the transcripts represent edited versions of participants' perception of their social

interactions. Further, the variety in degree of indiscriminate friendliness amongst the sample could be criticised, however this variation may potentially reflect a spectrum on severity on which young people may fall on (H. Minnis, 2007, personal communication, July 3, 2007). Placement on such a spectrum may be dependent upon many factors such as maltreatment experience or age. Indeed, there is a suggestion that indiscriminate friendliness decreases with age (H. Minnis, personal communication, July 3, 2007) which may indicate that this interaction style naturally lessens with age or that individuals learn more socially bounded behaviour.

It should also be noted that the participants did not identify their indiscriminate friendliness as being problematic, indeed, many were unable to identify this behaviour within themselves. As a result it was difficult to gain information about this topic during interviews. This contrasted greatly to guardian's views on the topic who described their child's indiscriminate friendliness as being problematic.

The label 'indiscriminate friendliness' has potential to pathologise this group of children. While this could be considered a harmful it can also be argued that the use of such labels facilitates research which can result in a elaborated understanding of this style of interaction. Use of this term also validates the concerns expressed by parents and facilitates access to health professionals who may be able to assist in making social relationships more accessible for this group of children. We must also question whether 'indiscriminate friendliness' is merely a social construction. Social constructionists propose that constructs, such as indiscriminate friendliness, are merely interpretations made by an observer (Banister, Burman, Parker, Taylor & Tindall, 1994) rather than descriptions of underlying structures as proposed by the realist perspectives. This perception that indiscriminate friendliness as being

constructed by researchers could be waged against the foundations of this piece of work. However, the realist approach is adhered to here due to the reliable recognition of the behaviour by clinicians and carers which provides support for a concept which I believe is beneficial to this group of children.

### Strengths

The recruitment strategy employed recruited young people via clinical and non-clinical routes which could suggest that the findings are relevant to both populations; although caution must be heeded due to the small sample characteristic of qualitative methodology. Yet, the benefits of qualitative methodology have been great as a new understanding of indiscriminate friendliness has been illuminated offering a fresh perspective from which to view the unusual interaction patterns observed in children with histories of maltreatment and care placements. The phenomenological perspective ensured that the perceptions and motivations of the individual children were represented within the emergent themes. Content validity was assured through consultation with a researcher experienced within the study of Reactive Attachment Disorder. The use of established questionnaires to support the perceived indiscriminate friendliness reported by clinicians and guardians and the existence of peer relationship difficulties gave strength to the recruitment route employed.

### Future Recommendations

The emergent themes identified can be incorporated into the the existing understanding of indiscriminate friendliness, add to the continuing diagnostic debate and influence clinicians' understanding of young people's social interactions. Limitations were placed upon the participants ability to reflect upon their experiences due to their levels of cognitive development and the possible stigma they



may have felt in revealing information about their behaviour. It would be interesting to interview older adolescents, or young adults, who may be less influenced by such issues to ascertain their understanding of previous indiscriminately friendly behaviour. Such an insight may validate the findings found here. Children referred due to their indiscriminately friendly behaviour may benefit from interventions targeted towards the development of security within relationships and an appreciation of the variability of potential friendships. This would be a development from the global approach towards social development which is typically described within the literature for maltreated children (Bennett, 2007).

### Conclusions

Research on indiscriminate friendliness is in its' infancy and the knowledge available largely relies upon quantitative studies, typically of samples from orphanages. This piece of research offers a depth of understanding from the young persons' perspective on the topic of indiscriminate friendliness. The validity of this information offers potential insights into the motivations and understanding behind the social interactions of this group of vulnerable children. Further, the themes identified fit together in a complementary style and each provides a context from which to fully appreciate the other themes. The use of Interpretative Phenomenological Analysis has given voices to young people who have been able to shed some light onto their perceptions of a behaviour which many clinicians have had difficulty comprehending.

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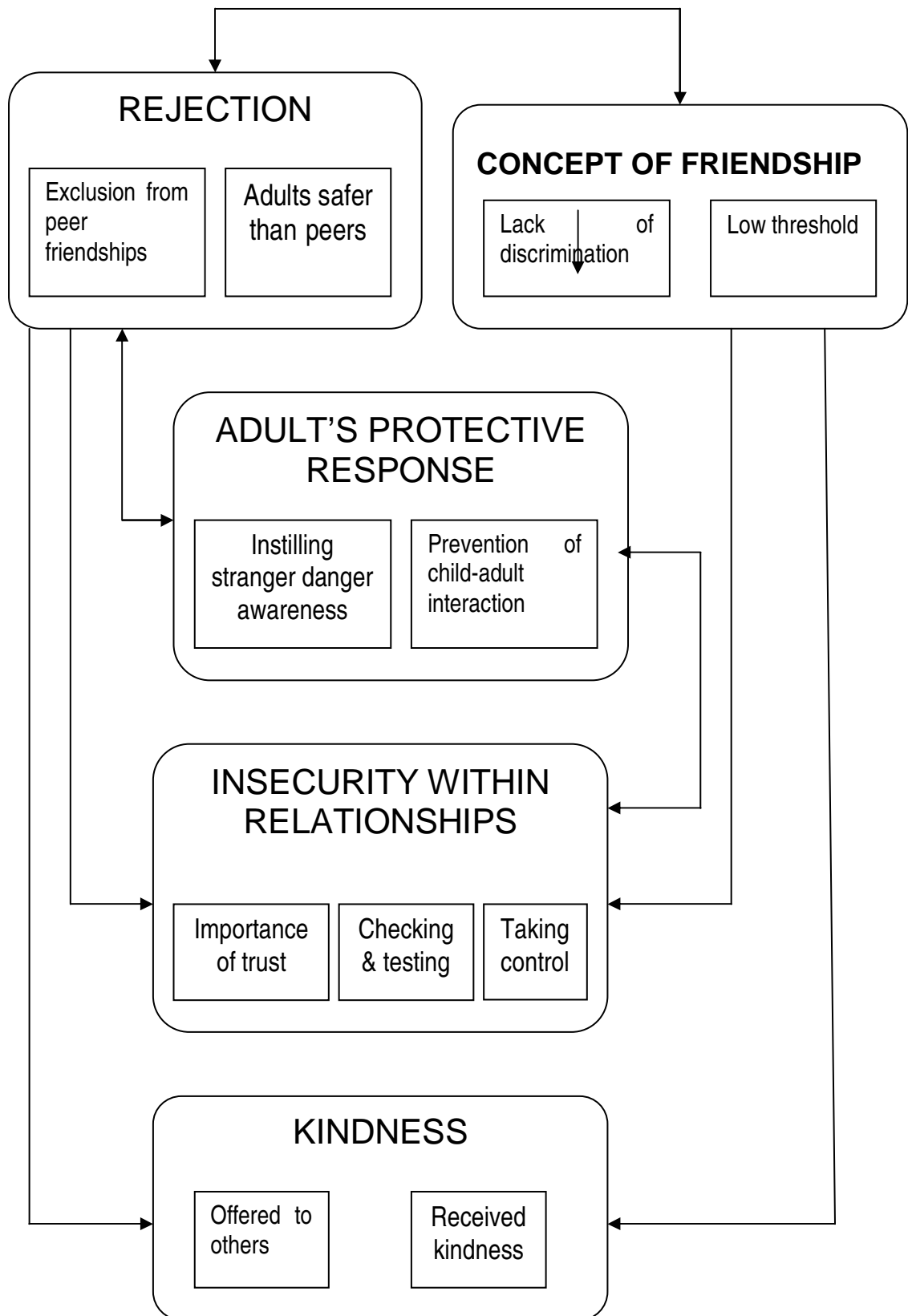
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Figure 4.1 Model of emergent themes resulting from an exploration of indiscriminate friendliness.



*Table 4.1 History, relationship problems and strengths and difficulties scores for each participant.*

Participant	Age (years)	Abuse/ Neglect History	Diagnoses	RPQ 4- item score	Care history	SDQ - Emotional problems	SDQ - Conduct problems	SDQ - Hyperactivity problems	SDQ - Peer relationship problems	SDQ -Total difficulties score	SDQ - Prosocial score
Jennie	14	Yes	RAD ADHD	12	Adopted/ Residential Care	Very high	Very high	Very high	Very high	Very high	Very low
Jody	9	Yes	---	10	Adopted	Very high	Very high	Slightly raised	Very high	Very high	Close to average
Hayley	9	Suspected	ADHD	12	Birth parent	Very high	Very high	Very high	Very high	Very high	Close to average
Matt*	10	Yes	RAD ADHD	6	Birth parent	Very high	Very high	High	Very high	Very high	Close to average
Samantha	10	Yes	---	12	Birth family member	Very high	Very high	Very high	Very high	Very high	Close to average
Elizabeth	14	Yes	Fetal Alcohol Syndrome	9	Adopted	High	Very high	Slightly raised	Very High	Very high	Very low
Claire	12	Yes	Fetal Alcohol Syndrome	7	Adopted	Very high	Close to average	Very high	High	Very high	Close to average
Arun	13	None	---	7	Birth parent	Close to average	Very high	Very high	Very high	Very high	Close to average
Ryan	10	Yes	ADHD	5	Residential Care/ Fostered	Close to average	Very high	Very high	Very high	Very high	Close to average

Note: \* Did not take part in an interview, \*\* Abuse history not accessible; RAD = Reactive Attachment Disorder; SDQ – where parent and self-ratings differed the rating suggesting greater difficulties is given; ADHD = Attention Deficit Disorder

*Table 4.2 Overview of emerging themes and sub-themes*

Emerging themes	Sub-themes
1 Concept of friendship	Low threshold Lack of discrimination
2 Rejection	Exclusion from friendships Adults perceived as safer than peers
3 Insecurity within relationships	Importance of trust Checking and testing Taking control
4 Adult's protective response	Instilling 'stranger danger' awareness Prevention of child-adult interaction
5 Kindness	Offered to others Received kindness



## CHAPTER FIVE: SINGLE CASE RESEARCH PROPOSAL

Evaluating the effect of a brief anxiety intervention for  
maternal anxiety upon a 12 year old boy's hairpulling and  
maternal safety behaviour of checking

( Abstract only)

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*Submitted in partial fulfilment of the requirements for the degree of Doctorate in  
Clinical Psychology (D.Clin. Psy)*

## Abstract

**Relevant literature:** Hairpulling among children and adolescents typically lacks the symptoms of urges and relief dictated by diagnostic criteria. Therefore, hairpulling within this age group is typically considered within the trichotillomania diagnostic framework regardless of the lack of these symptoms. Research to date has primarily been reliant on case studies which has suggested that psychoeducation and behavioural interventions are the most effective forms of intervention and that anxiety related triggers are implicated.

**Case description:** A 12-year-old boy was referred for treatment of repeated hairpulling from his scalp and eyelashes. A number of stressors were identified within the family which may have triggered hairpulling. The family had instigated a number of preventative and checking strategies with the aim of reducing John's<sup>9</sup> hairpulling.

**Hypothesis:** It is hypothesised that a reduction in maternal anxiety will be associated with a reduction in time spent hairpulling and maternal checking.

**Proposed methodology:** An A<sup>1</sup>B<sup>1</sup>B<sup>2</sup>A<sup>2</sup> design is proposed. Phase A<sup>1</sup> is a baseline assessment, Phase B<sup>1</sup> is a brief anxiety intervention for John's mother, Phase B<sup>2</sup> is an anxiety intervention maintenance period and Phase A<sup>2</sup> removes anxiety intervention provision. Assessments of maternal anxiety, checking and hairpulling are repeated throughout the experimental design. Clinician and child rated detailed trichotillomania assessments are also carried out.

**Ethical issues:** This is a proposed single-case design and is not being carried out. Consent has been provided by John and his mother for this proposal to be written. Should this design be carried out this would provide detailed information for the assessment and formulation of the maintenance of the presenting problem.

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<sup>9</sup> A pseudonym is used to protect the identify of the child.

## **APPENDICES**

*Chapter 1 Appendices: Small Scale Service Related Project*

1. Data Collection sheet
2. Powerpoint presentation for Leverndale Clinical Psychology Meeting

## APPENDIX 1.1: Data Collection Sheet

### Patient Code: .....

Demographics

Gender: M/F

Age at time of referral (yrs): .....

Post code at time of referral: .....

Country of origin: .....

Ethnic Group: .....

Language: .....

### Referral

Source of referral: GP / CMHT /

Other.....

Date of referral: .... / .... / .....

Time between referral and 1<sup>st</sup> appointment offered: .....months

Presenting problem: .....

.....

.....

Interpreter required: yes / no

Psychology service : SE1 / SE2 /Camglen / Shawlands/Southwest

### Treatment

No.of sessions attended: .....

No. of DNAs: .....

No. of cancellations: .....

Interpreter used: yes / no

No. of sessions spoiled due to interpreter DNA: .....

Length of time in treatment: .....mths

Also attending group treatment: yes /no If yes, which group

.....

### Outcome

Reason for discharge:

↓ Treatment completed

↓ Moved to another area

↓ Other .....

↓ Refused asylum

↓ DNA

Referred elsewhere: yes / no If yes, where? .....

Still in treatment: yes / no

### Other

Contacts with other agencies: yes / no

If yes which agencies: .....

Also estimate how many i) letters ..... ii) GP letters..... iii) phone calls .....

iv) reports ..... v) face to face enquiries .....

*APPENDIX 1.2: Powerpoint Presentation for Leverndale Clinical Psychology Meeting*

## **Audit of asylum seekers accessing clinical psychology in the south of Glasgow**

Preliminary Report  
Julie Bennett

## **Common difficulties reported by asylum seekers**

- King's Fund (2000) - high levels of physical and mental health problems
  - ◆ anxiety, depression, trauma related symptoms, sleep difficulties
  - ◆ memory and concentration difficulties
- Acheson (1998)
  - ◆ links to both past experiences + current circumstances surrounding asylum

## **Overview**

- Background
- Method
- Results to date
- Clinical implications
- Remaining questions

## **Additional workload?**

- Drummond (2003)
  - ◆ significantly more letters, reports, phone calls and face to face meetings documented on behalf of asylum seeker patients in comparison to non-asylum seeker patients

## **Why audit asylum seekers?**

- Consultation with department
- Perceived high workload from this patient group
- Clark (2004) - common perception within Clinical Psychology
- Burnett & Peel (2001) - many and varying needs of asylum seekers
- Drummond (2003) - audit of North Glasgow Clinical Psychology

## **Method**

- Consultation with department
- Some really practical points to investigate
- referred to relevant literature
- previous audit carried out in north of Glasgow
- ➡ demographics, referral info, treatment info, outcome, onward referral, psychologist workload

## Sample

- All asylum seekers accessing clinical psychology services within the south of Glasgow between 1st July 2003 and 30th June 2004.
- Identified via:
  - ◆ clinical psychologists
  - ◆ Compass database
  - ◆ referral files

## Results - Nationality + language

- Majority originated from Turkey (N=10)
  - ◆ N=5 Iran
  - ◆ N=3 Kosovo
  - ◆ N=3 Algeria
  - ◆ N=3 Afghanistan
  - ◆ N=1 Azerbaijan, Serbia, Sri Lanka, Palestine, Kurdistan, Iraq, Burundi
- Turkish predominated as 1st language (N=9)
- remaining patients spoke Farsi, Albanian, French, Azzai, Tamil, Iranian, Kurdish + Swahili

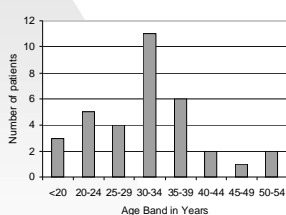
## Preliminary results

- Data collected for 34 patients

## Results - Referrals

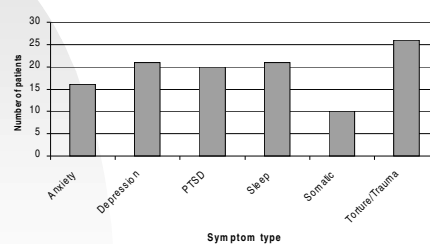
- 83% referred from GPs
  - ◆ remainder from CPNs, dental hospital, Compass team + psychiatry
- majority in Greater Shawlands (60%)
  - ◆ 24% Castlemilk
  - ◆ 15% Gorbals
  - ◆ 6% southwest

## Results - Demographics

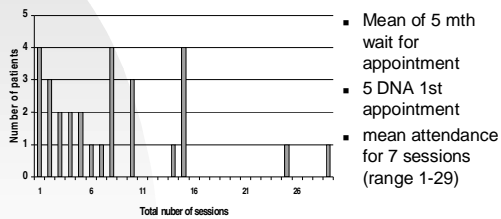


- N=22 / 65% male
- N=12 / 35% female
- half (N=17) aged 30-39 years

## Results - Reason for referral



## Results - Treatment



## Results - Workload

- Average amount of work additional to psychology sessions per patient
  - ◆ 2 GP letters
  - ◆ 1 phone call
  - ◆ <1 additional letter, reports, face-to-face contacts

## Results - Discharge

- Mean length of treatment = 5 months
- 4/12 women attended Compass group
- 2/22 men attended Compass group
- 4 still in treatment at current time
- Majority discharged due to DNA or treatment completed
- Remainder discharged due to moved area, patient chose to end treatment and psychologist leaving service

## Clinical implications

- Is this a realistic picture? Are all phone calls etc. being logged? Importance of record keeping (Clark, 2004)
- High loading of referrals from asylum seekers in Greater Shawlands
- ➡ spread referrals to psychologists in other areas?
- ➡ request additional support for work with asylum seekers?
- Research impact of high caseload of asylum seekers

## Results - Onward referral

- Only 6 patients were referred onwards by psychologist:
  - ◆ another psychologist for follow-up
  - ◆ Scottish Refuge Council
  - ◆ Community Mental Health Team
  - ◆ Ethnic Minority Law Centre
  - ◆ Compass team
  - ◆ Housing services

## Remaining questions

- Link between treatment type and treatment length?
- Stage of asylum process and type of treatment engaged in?
  - ◆ Maslow's hierarchy of needs



## *Chapter 2 Appendices: Systematic Review*

1. *Child Development Submission Guidelines*
2. *Quality criteria assessment sheet*
3. *Description of social competence measures*

# Child Development



Child Development

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## APPENDIX 2.2 *Quality criteria assessment sheet*

Quality Checklist: The impact of childhood maltreatment upon children's social competence in peer interaction – a systematic review <sup>10</sup>			
Author			
Title			
Year of publication			
Journal title			
Checklist completed by:			
AIMS & GENERAL PROCEDURE			
1.1	Are hypotheses clearly stated?	Well / adequately stated Poorly / not stated	1 0
1.2	Were the procedures clearly stated?	Well / adequately stated Poorly / not stated	1 0
1.3	Were the main potential confounders identified and taken into account in the design and analysis? <i>e.g. socio-economic background, IQ, receptive language entered into regression</i>	Well / adequately addressed Poorly / not addressed	1 0
1.4	What design was used?	Longitudinal Cross-sectional Other (e.g. case study)	2 1 0
<b>TOTAL: AIMS &amp; GENERAL PROCEEDURE</b>			<b>/ 5</b>
SAMPLE			
2.1	Were the groups studied selected from comparable populations that are comparable in all respects other than the factor under investigation? <i>e.g. same school, geographical area, SES, social work involvement – were the samples well matcher?</i>	Yes No / Unclear	1 0
2.2	Were response rates cited + contrasts made between these and those not opting-in?	Rates cited + contrasts made Rates cited but no contrasts Not addressed	2 1 0
2.3	Were drop-out rates cited + contrasts made between these and those remaining in study?	Rates cited + contrasts made Rates cited but no contrasts Not addressed / not applicable	2 1 0
2.4	Was appropriate demographic information provided on maltreated and non maltreated samples? <i>i.e. age, gender, socio-economic class, ethnic origin</i>	Well / adequately addressed Poorly / not addressed	1 0
<b>TOTAL: SAMPLE</b>			<b>/ 6</b>
ASSESSMENT			
3.1	Was an explicit definition of maltreatment employed? <i>i.e. x, y, and z are classified as maltreatment within this study</i>	Examples of MT (e.g. hit, burnt) Identification of subtypes (e.g. Physical, sexual) Vague definition / none supplied	2 1 0
3.2	Was the social competence construct measured clearly defined? <i>e.g. friendship quality, social preference ratings, peer popularity, social competence vs. a vague social competence composite score.</i>	Explicit definition Vague definition / none supplied	1 0
3.3	Was the measure of Social Competence employed demonstrated to be valid? <i>Rater's subjective opinion = considered to be an</i>	Referred to published validity of measure Subjectively considered valid	2 1

<sup>10</sup> Adapted from SIGN, Methodology Checklists, 2004

	<i>appropriate measure of identified social competence construct</i>	measure of identified social competence construct being measured No / not addressed	0
3.4	Was the measure of Social Competence employed demonstrated to be reliable?	Referred to published information Refers to own reliability assessment only Not addressed	2 1 0
3.5	Were peer ratings of social competence included? <i>e.g. sociometric nominations</i>	Yes No	1 0
3.6	Was more than 1 type of social competence rater included? <i>i.e. peers, teachers, parent, child</i>	Yes No	1 0
3.7	Did measures of Social Competence include direct observation of peer interaction? <i>i.e. coding an interaction between peers</i>	Yes No	1 0
3.8	Were the measures employed suitable for use with children and adolescents?	Yes No	1 0
3.9	Were the assessors blind to history of maltreatment? NB. Partially if assessors blind for only some assessments	Yes Partially No	2 1 0
<b>TOTAL: ASSESSMENT</b>			<b>/ 13</b>
<b>STATISTICAL ANALYSIS</b>			
4.1	Are analyses carried out clearly associated with hypotheses?	Yes No	1 0
4.2	Were strategies employed to account for multiple contrasts? <i>e.g. Bonferroni corrections or more stringent p levels where multiple contrasts were carried out</i>	Yes No	1 0
4.3	Was a power analysis carried out? If so was the appropriate sample size recruited?	Power calculation + appropriate sample size recruited Power calculation but insufficient participants Not addressed	2 1 0
4.4	Were results clearly reported?	Clearly reported Poorly reported	1 0
<b>TOTAL: STATISTICAL ANALYSIS</b>			<b>/ 5</b>

<b>TOTAL: AIMS &amp; GENERAL PROCEEDURE</b>	<b>/ 5</b>
<b>TOTAL: SAMPLE</b>	<b>/ 6</b>
<b>TOTAL: ASSESSMENT</b>	<b>/ 13</b>
<b>TOTAL: STATISTICAL ANALYSIS</b>	<b>/ 5</b>
<b>OVERALL TOTAL</b>	<b>/ 29</b>
<b>%</b>	
<b>QUALITY RATING: POOR (&lt;50%), MODERATE (50-74%), GOOD (&gt;75%)</b>	

## Appendix 2.3 Description of Social Competence Measures

Social Competence Measure	Description
<b>SOCIOMETRIC AND PEER NOMINATIONS MEASURES</b>	
Revised Class Play - Masten, Morison & Pellegrini, 1985	Pupils select classmates who portray each specified role, e.g. makes friends easily, picks on other kids, feelings get easily hurt. 30 roles. Three factors: Sociability-Leadership, Aggressive-Disruptive, Sensitive-Isolated (can be split into Passive-Withdrawal and Active-Isolation)
Peer Ratings of Social Behavior - Salzinger, Feldman, Hammer & Rosario, 1993	6 items on a 5 point likert scale. Shy, leader, fight, cooperate, pick on others, get attention
Peer Nominations - Coie & Dodge, 1983	Peer assessed. Nominate a peer for each category, e.g. cooperative, leader, shy, liked most. Total number of nominations for each individual converted into proportions of possible nominations.
Sociometrics: social preference score - Coie, Dodge & Coppotelli, 1982; Dodge, 1983; Asher, Singleton, Tinsley & Hymel, 1979	Children presented with alphabetised list of their class and asked to nominate 3 children whom they like the most and 3 whom they like the least. Social preference calculated by difference between liked-most and like-least nominations. Simplified versions for younger children.
<b>OBSERVATIONAL</b>	
Friendship Observation Scale (FOS) - Flyr, Howe & Parke, 1996	Two 10-minute observation periods (free play + semi-competitive board game). One observer rates each child's interaction skills + dyadic relationship properties. Third rater provides inter-rater reliability ratings in 30% of observations.
<b>RATING SCALES</b>	
<i>Child/Peer Rated</i>	
Instrumental and Social Competence Scale - Beiser, 1988	Social competence subscale, 12 parent items + 9 youth items, 4 point Likert scales.
Friendship quality: Network of Relationships Inventory - Furman & Buhrmester, 1985	Rate relationship with best friend on: affection, instrumental aid, companionship, intimacy, satisfaction with relationship + conflict
Reciprocal best friend - Bolger, Patterson & Kupersmidt, 1998	Asked if they have a best friend. If this reciprocated score positively.
Peer Social Network Diagram (PSND) - Parker & Herrera, 1996	Name all friends (not adults, pets etc.). Classify each into best friends, good friends and casual friends.
Piers-Harris Children's Self-concept Scale (PCSC) - Piers, 1986	80-item self-report, 8-18 yrs. Behaviour, intellectual and school status, anxiety, popularity, happiness and satisfaction subscales.
Self-Perception Profile for Children-Revised (SPPC), Harter, 1985	6-item social competence subscale. 4-point response scale. Higher scores indicating a more positive perception (range 6-24).
Measure of Social Expectations - Salzinger, Feldman, Ng-mak, Mojica & Stockhammer, 2001.	Who in your class will choose you positively and negatively? Contrast with actual sociometric nominations.
Friendship Quality Questionnaire (FQQ) - Parker & Asher, 1993	41-item questionnaire assessing quality of children's friendships. Subscales: Validation and Caring, Conflict Resolution, Conflict and Betrayal, Help and Guidance, Companionship and Recreation, Intimate Exchange.
Friendship Contact Checklist - Parker & Herrera, 1996	List of potential activities carried out with friends.
Friendship Attributes Q-sort (FAQS) - Parker, Saxon, Houlihan & Casas, 1996	Card sorting task to assess perceptions of features of relationship with a specific friend. 68 statements on cards.
<i>Teacher Rated</i>	
Teacher's Checklist of Children's Peer Relationships and Social Skills (TCS) - Coie & Dodge, 1988	17 items, 5-point Likert scales. Prosocial behaviour, social sensitivity, task performance, aggressive behaviour in school.
Teacher's Rating of child's Actual Behavior - Harter, 1985	Subscales include: cognitive competence, social acceptance, physical competence. Forms for older and younger children.
Teacher's Rating of Perceived Competence (TRPC) - Harter, 1985	<8yrs, 4-point Likert scale. Teacher-rated measure on cognitive competence, physical competence and peer acceptance
Teacher Report form of the Child Behavior Checklist - Achenbach & Edelbrock, 1981	Teacher's version of Achenbach Child Behavior Checklist (see adult ratings section).
Preschool Behaviour Questionnaire (PBQ) - Behar & Stringfield, 1977	30-item teacher-rated scale measuring maladaptive social + classroom behaviour hostile-aggressive, anxious-fearful, hyperactive-distractible subscales.
Taxonomy of Problematic Social Situations for children (TOPS) - Dodge et al., 1985	44-item (5-point Likert scale) measure assessing likelihood that a child will respond inappropriately across 8 categories of difficult social situations (e.g. responding to failure, attempting to initiate peer-group entry).
<i>Other Adult Ratings</i>	
Achenbach Child Behavior checklist (CBCL) - Achenbach, 1991	3 point Likert scale. 6 scores representing number of organizations child belong, their participation, number of friends, interaction with friends, behaviour with others and ability to play/work alone (range 22-55). Problem behaviours inc. aggression, defiance, non-compliance, impulsivity, antisocial acts, fearfulness, anxiety → internalising and externalising factors.
Ratings of Child's Competence (RCC) - Harter, 1985	3-item social competence subscale measuring adult's perception of quality of child's peer relationships.
Behavior Ratings - Wright, 1983	9 items (7-point Likert scale) on prosocial behaviour, aggression and withdrawal
California Child Q-Set (CCQ Set) - Block & Block, 1969	100 items about child's personality, cognitive and social characteristics to organise into order of most to least descriptive. Results in a profile which is compared with prototype profiles of social competence.
OB-SOCIAL observations	Based on Parten's (1933) work on children's play with peers. Social competence relevant for playground context. Scored on highest sustained play (i.e. play for longer than 2mins) during 10mins observation segments: disengaged from environment, played alone, observed another child without joining in, played next to another child, engaged in associative play, cooperative organized play with mutual goal
Pupil Evaluation Inventory - Pekarik, Prinz, Liebert, Weintraub & Neale, 1976	Nomination technique of 35 items assessing social behaviour → aggression, withdrawal and likability factors.

#### *Chapter 4 Appendices: Major Research Project*

1. Manuscript submission guidelines
2. Ethics committee approval letter
3. Research and Development approval letter
4. Clinician recruitment flier
5. Adoption UK recruitment flier
6. Covering letter
7. Invitation
8. Guardian information sheet
9. Child information sheet
10. Guardian consent form
11. Child consent form
12. Interview recording consent form
13. Relationship Problems Questionnaire items
14. Interview Schedule
15. Scenarios
16. Example of notes and exploratory codes from section of transcript with section of control theme quote table

## Appendix 4.1: Manuscript submission guidelines

# Clinical Child Psychology and Psychiatry

### Editor:

Bernadette Wren

Tavistock Clinic, London, UK

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## Manuscript Submission Guidelines:

### AIMS AND SCOPE

*Clinical Child Psychology and Psychiatry* brings together clinically oriented work of the highest distinction from an international and multidisciplinary perspective, offering comprehensive coverage of clinical and treatment issues across the range of treatment modalities. The journal is interested in advancing theory, practice and clinical research in the realm of child and adolescent psychology and psychiatry and related disciplines. The journal directs its attention to matters of clinical practice, including related topics such as the ethics of treatment and the integration of research into practice.

Multidisciplinary in approach, the journal includes work by, and is of interest to, child psychologists, psychiatrists and psychotherapists, nurses, social workers and all other professionals in the fields of child and adolescent psychology and psychiatry.

### INSTRUCTION TO AUTHORS

*Peer review process.* The Editor will screen manuscripts for their overall fit with the aims and scope of the journal. Those that fit will be further reviewed by two or more independent reviewers. Papers will be evaluated by the Editorial Board and refereed in terms of merit, readability and interest. Unsolicited manuscripts will not be returned to the author.

*Consent and confidentiality.* Disclosure should be kept to a minimum necessary to fulfil the objective of the article. All identifying details should be omitted if they are not essential. The material should be further disguised so that none of the individuals involved could recognise themselves. Some material that is particularly distinctive should be omitted or aggregated. Patient consent to publish should be sought whenever possible, even if the data are anonymized. In case reports where ensuring anonymity is impossible, written consent must be obtained from the clients described, or their legal representative, and submitted with the manuscript. Contributors to the journal should be aware of the risk of complaint by individuals in respect of defamation and breach of confidentiality. If there is concern, then authors should seek legal advice. Authors submitting research reports should confirm that approval from the appropriate ethical committee has been granted.

*Conflict of interest* Authors should make clear if the research has been funded, by whom, and the role of the funders in the project.

*Complaints* The Editor will respond promptly to complaints. Cogent criticism from readers will be taken seriously and considered for publication. Authors of criticized material will be given the opportunity to have a response published.

*Submission of MSS.* Articles may be submitted by email initially for the Editor's screening. Subsequently, four copies of each manuscript, **typed in double spacing throughout**, and on one side only of white A4 or US standard size paper, and a copy on disk (preferably PC compatible) should be sent to the Editor at the address given below. All pages should be numbered.

*Format of MSS.* Each manuscript should contain the following, in the correct order.

(a) Title page to include the title of the paper, full name of each author, current professional position and work context, and indicators of which author will be responsible for correspondence. A word count should also be included.

(b) Abstract: should not exceed 200 words (150 for preference); up to **5 key words to be listed alphabetically on the same page**. This page should carry the title of the paper but not the author name(s).

(c) Main text: not usually to exceed 7500 words and to be clearly organized, with a clear hierarchy of headings and subheadings (3 weights maximum).

(d) References: Citation of references follows APA (American Psychological Association) style. References cited in the text should read thus: Brown (1955, pp. 63-64); (Brown, 1995, pp. 63-64; Green & Brown, 1992, p. 102, Table 3). The letters a, b, c, etc., should distinguish citations of different works by the same author in the same year (Black, 1989a, 1989b).

All references cited in the text should appear in an alphabetical list, after the Notes section.

(e) Figures, tables, etc.: should be numbered consecutively, carry descriptive captions and be clearly cited in the text. Keep them separate from the text itself, but indicate an approximate location on the relevant text page. Line diagrams should be presented as camera-ready copy on glossy paper (b/w, unless to be reproduced - by arrangement - in colour) and, if possible, on disk as EPS files (all fonts embedded) or TIFF files, 800 dpi - b/w only. For scanning, photographs should preferably be submitted as clear, glossy, unmounted b/w prints with a good range of contrast or on disk as TIFF files, 300 dpi.

(f) Author biographies: On a separate sheet provide a one-paragraph biobibliographical note for each author - up to 100 words for a single author, but none to exceed 65 words in a multi-authored paper.

*Style.* Use a clear and readable style, avoiding jargon. If technical terms must be included, define them when first used. Use plurals rather than he/she, (s)he, his or hers: 'If a child is unhappy, he or she . . . ' is much better expressed as 'When children are unhappy, they . . . '.

*Spelling.* British or American spellings may be used ('z' versions of British spellings preferred to 's' versions, as given in the Oxford English Dictionary).



*Punctuation.* Use single quotation marks, with double inside single. Present dates in the form 9 May 1996. Do not use points in abbreviations, contractions or acronyms (e.g. DC, USA, DR, UNESCO).

*Covering letter.* Attach to every submission a letter confirming that all authors have agreed to the submission and that the article is not currently being considered for publication by any other journal. The name, address, telephone and fax number and email address of the corresponding author should always be clearly indicated.

*Copyright.* Before publication authors are requested to assign copyright to Sage Publications, subject to retaining their right to reuse the material in other publications written or edited by themselves and due to be published preferably at least one year after initial publication in the Journal.

*Mailing.* Address MSS to the Editor: **Dr Bernadette Wren, Consultant Clinical Psychologist, Child and Family Department, Tavistock Clinic, 120 Belsize Lane, London NW3 5BA, UK. Tel: +44 (0)20 8938 2282. Email: BWren@tavi-port.nhs.uk**  
North America: **Prof. John Leventhal, Yale University, Section of Paediatrics, School of Medicine, 333 Cedar Street, PO Box 208064, New Haven, Connecticut. Tel: 001 203 688 2468 Fax: 001 203 785 3932. Email: John.Leventhal@Yale.Edu**

## Appendix 4.2: Ethics committee approval letter

### Primary Care Division

Divisional Headquarters  
Gartnavel Royal Hospital  
1055 Great Western Road  
GLASGOW G12 0XH  
Telephone 0141 211 3600  
[www.nhs.gov.uk](http://www.nhs.gov.uk)



Dr Julie Bennett  
Trainee Clinical Psychologist  
University of Glasgow, Section of  
Psychological Medicine  
Division of Community Based Sciences  
Academic Centre, Gartnavel Royal Hospital  
1055 Great Western Road, Glasgow  
G12 0XH

Date 15 November 2006  
Your Ref  
Our Ref  
  
Direct line 0141 211 3824  
Fax 0141 211 3814  
E-mail Liz.Jamieson@gartnavel.  
glacomen.scot.nhs.uk

Dear Dr Bennett

**Full title of study:** A qualitative exploration of childrens' understanding of  
indiscriminate friendliness

**REC reference number:** 06/S0701/130

Thank you for your letter of 30 October 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

### Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

### Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	One	31 July 2006
Investigator CV	JB	22 August 2006
Protocol	One	31 July 2006
Covering Letter	One	22 August 2006



INVESTOR IN PEOPLE

Covering Letter		30 October 2006
Summary/Synopsis		31 July 2006
Interview Schedules/Topic Guides	One	31 July 2006
Questionnaire	One	31 July 2006
Letter of invitation to participant		
GP/Consultant Information Sheets	One	31 July 2006
Participant Information Sheet	One	31 July 2006
Participant Information Sheet: Child Information Sheet	Two	09 October 2006
Participant Information Sheet: Parent Information Sheet	Two	09 October 2006
Participant Information Sheet: Information for Children	Version 3	30 October 2006
Participant Information Sheet: Information for Parents	Version 3	30 October 2006
Participant Consent Form: Parent/Guardian Consent Form	Two	09 October 2006
Participant Consent Form	One	31 July 2006
Response to Request for Further Information	Letter	
Response to Request for Further Information	Email	30 October 2006
Interview Recording Form	One	09 October 2006
Focus Group Invitation/Information Sheet	One	09 October 2006
CV for Supervisor	HM	
CV for Supervisor	CAE	01 August 2006

### Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**06/S0701/130**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



**Liz Jamieson**

**Research Ethics Committee Co-ordinator on behalf of Dr Paul Fleming, Chair**

Enclosures:

Standard approval

Site approval form

Copy to:

R&D Department for NHS care organisation at lead site

### Appendix 4.3: Research and Development approval letter

#### Primary Care Division

Research & Development Directorate

Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow G12 0XH  
Tel: 0141 211 3600  
[www.nhsgg.org.uk](http://www.nhsgg.org.uk)



Dr Julie Bennett  
Trainee Clinical Psychologist  
Department of Psychological Medicine  
Gartnavel Royal Hospital  
Glasgow  
G12 0XH

Date 21 November 2006  
Your Ref  
Our Ref BR/AW/approve  
Direct Line 0141 211 3661  
Fax 0141 211 3814  
Email [annette.watt@](mailto:annette.watt@gartnavel.gla.ac.uk)  
[gartnavel.gla.ac.uk](mailto:gartnavel.gla.ac.uk)

Dear Dr Bennett

**Project Reference Number: PN06CP019**

**Project Title: A qualitative exploration of the phenomenon of social disinhibition from the perspectives of children with Reactive Attachment Disorder and Children with Attention Deficit Hyperactivity Disorder**

Thank you for submitting a Research & Development (R&D) Management Approval Application for the above study. I am pleased to inform you that R&D management approval has been granted by NHS Greater Glasgow & Clyde Community & Mental Health Partnership subject to the following requirements:

- You should notify me of any changes to the original submission and send regular, brief, interim reports including recruitment numbers where applicable. You must also notify me of any changes to the original research staff and send CVs of any new researchers.
- Researchers covered by this approval are:- Dr J Bennett; Dr H Minnis; Prof C Espie
- Your research must be conducted in accordance with the National Research Governance standards. (see CSO website: [www.show.scot.nhs.uk/cso](http://www.show.scot.nhs.uk/cso)) Local Research Governance monitoring requirements are presently being developed. This may involve audit of your research at some time in the future.
- You must comply with any regulations regarding data handling (Data Protection Act).
- A final report, with an abstract which can be disseminated widely within the NHS, should be submitted when the project has been completed.

Do not hesitate to contact the R & D office if you need any assistance.

Thank you again for your co-operation.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'A. Watt' or similar, written over a horizontal line.

PP

**Brian Rae**  
**Research Manager**



## Recruitment Plea: Indiscriminate Friendliness Study



strangers without any hesitation, treating teachers as peers, wandering off without checking back with their parent or carer and disregarding social boundaries. We might also describe this type of behaviour as socially disinhibited.

- ...who are able to  *speak about their social experiences.*
- ...some of these children  *might* have diagnoses of Reactive Attachment disorder, Attention Deficit Disorder or some other psychiatric disorder.
- ...who are currently, or who have previously been in contact with psychiatric services associated with Yorkhill Hospital.
- ...who do not have a diagnosis of a Learning disability.

### *If families opt-in to the study we ask ...*

- ...the child and a parent/carers to complete Strengths & Difficulties Questionnaires and the Relationships Problems Questionnaire.
- ...the child and a parent/carers to meet with myself for a brief meeting at a location which is easy for them to get to.
- ...the child to meet with me for an additional 30 minutes to speak about their social experiences.

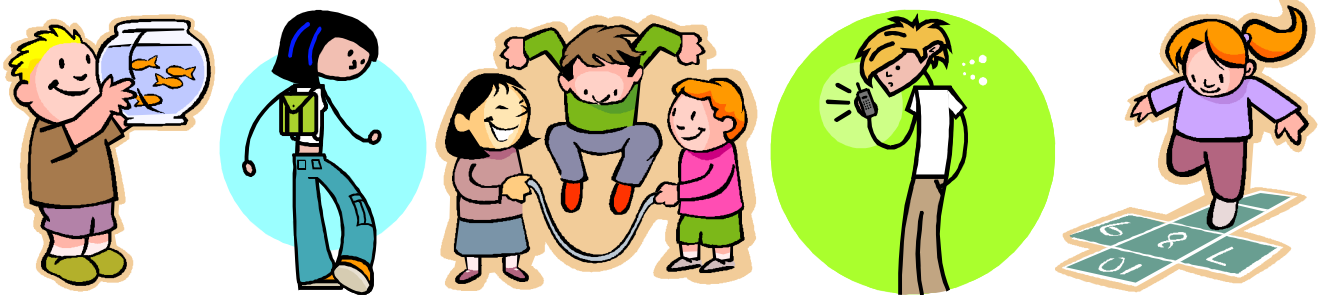
**Maybe you have someone in mind who might be able to help me out? If you do please send them out an invitation pack or even get in touch with myself to discuss any children you feel may be suitable. Also, if you're looking for more information packs please do get in touch. Looking forward to hearing from you.**

Julie Bennett

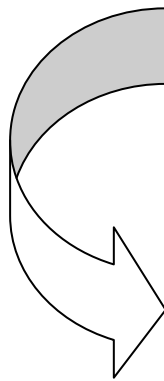
Trainee Clinical Psychologist  
(07941 410 421 / [j.bennett.1@research.gla.ac.uk](mailto:j.bennett.1@research.gla.ac.uk))



## Can you and your child help us with our research on indiscriminate friendliness?



- ...speak to strangers without worrying about doing this?
- ...easily go off with strangers?
- ...ask strangers for help or comfort them when they could have asked you instead?
- ...get upset when they have to leave strangers?



If you answered yes to any of these questions it sounds as if we would really like your child to take part in our research!

We are hoping to speak to some children and young people aged between 8 and 16 years about their indiscriminately friendly behaviour. If you would be interested in finding out some more about the research please contact Julie Bennett for an information pack.

You can contact Julie at [j.bennett.1@research.gla.ac.uk](mailto:j.bennett.1@research.gla.ac.uk), on 07941 410421 or at Psychological Medicine, Division of Community Based Sciences, Academic Centre, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH.

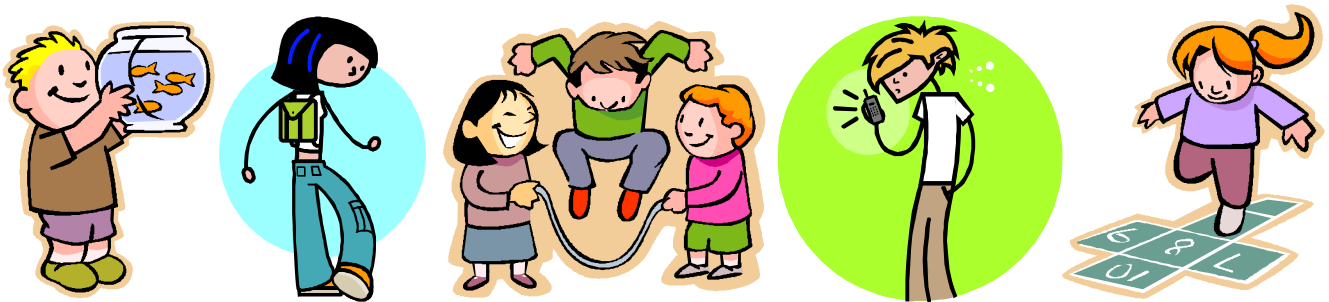
We're looking forward to hearing from you!

*Appendix 4.6: Covering letter*

Psychological Medicine  
Division of Community Based Sciences  
Academic Centre  
Gartnavel Royal Hospital  
1055 Great Western Road  
Glasgow G12 0XH



An Exploration of Children's Experience of  
Indiscriminate Friendliness



Please find enclosed an invitation for your child to take part in a piece of research about indiscriminate friendliness. You are receiving this pack because your child's doctor suggested that your child might be able to help us with this research and they have forwarded this information pack to you **or** you have got in touch with us yourself after seeing one of our adverts.

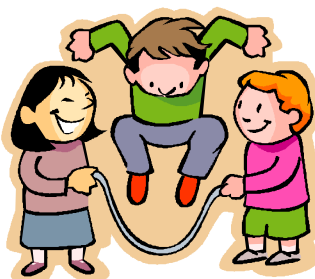
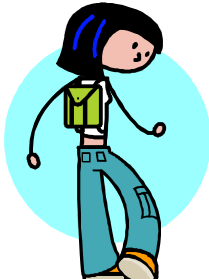
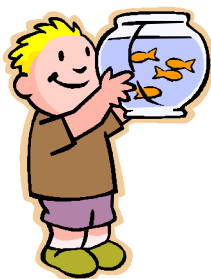
Please take some time to read the information in this pack. We look forward to hearing from you soon!

Yours sincerely

Dr Julie Bennett  
Trainee Clinical Psychologist

Dr Helen Minnis  
Senior Lecturer

## An Invitation!



sheet for you and one for your parents/guardians which will tell you all about the research. There's also a sheet which will help you work out if you can help us out!

If you decide you would like to take part please get in touch with us within the next two weeks by filling out the consent form in this pack. You'll need to get your parent/guardian to sign a form as well.

If you have any questions about why you have been contacted by us or you would like some more information please contact Dr Julie Bennett on 07941 410 421 or email her on [j.bennett.1@research.gla.ac.uk](mailto:j.bennett.1@research.gla.ac.uk)

Dr Julie Bennett

Dr Helen Minnis





Information for Parents:  
An Exploration of Children's Experience of  
Indiscriminate Friendliness



UNIVERSITY  
of  
GLASGOW

Your child is being invited to take part in a research study. Before you decide if they will offer to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. We have also sent you an information sheet for you child.

- Part 1 tells you the purpose of this study and what will happen to your child if they take part.
- Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish your child to take part.

### **PART 1**

Some children can be really friendly with people they don't know very well. Some children often wander off without checking back with their parents and they aren't worried about speaking to strangers. Sometimes children may even ask a stranger for help rather than their mum or dad. We call this type of friendliness 'indiscriminate friendliness'. Some children are indiscriminately friendly a lot of this time. Does this sound like your child? We are really interested in speaking with children who do these things!

#### **What is the purpose of the research study?**

We would like to find out more about this type of friendliness in children. Finding out more about the reasons why children are indiscriminately friendly will be helpful for families who struggle with having a child who behaves in this way and for professionals who try to support offer them support.

#### **Why has my child been chosen?**

Either, your child has seen a clinician who thought that your child would be able to speak with us about their indiscriminate friendliness, or, you have responded to an advert about the study.

#### **Does my child have to take part?**

*No. It is up to you and your child to decide whether or not to take part. You are both free to withdraw from the research at any time and without giving a reason.*

#### **What will happen to my child if we agree to take part?**

1. If you and your child decide that it's ok for them to help out in this study you each need to sign the consent form. Send these off in the envelope included in your invitation pack
2. We will send you 2 questionnaires to fill out about your child and 1 for your child to fill in about themselves. We will also ask you where is the best place for Julie Bennett to meet you and your child. You can then post these back to us.
3. After you have sent the questionnaires back Julie Bennett might arrange to meet with you and your child.
4. About a week later Julie Bennett will meet you and your child for a second time to speak with your child about times when they are really friendly with other people. This 'interview' will be taped if that's ok with you and your child.

And that's it!

Afterwards we will listen to the tapes of the conversations children have with us about friendliness and we'll write up a report of what people have said. Once that's finished we'll send you and your family a sheet telling you what we found out from our conversations with the children who helped us.

**What are the possible benefits of taking part?**

We cannot promise the study will help your child but the information we get might give us information which could help your child and other children have an easier time in getting on with people. This will assist professionals to support families where they have difficulty with their child's indiscriminate friendliness.

**What happens if my child no longer wants to take part in the study?**

That's fine. Just contact the research team and let them know. Unless you specify, they will use any information already collected via questionnaires or interviews.

.....  
: *Thank you for reading so far!* :  
: *if you are still interested, please look at Part 2.* :  
.....

**PART 2**

**Will my child's taking part in the research project be kept confidential?**

The clinician who suggested your child might like to take part in the study knows that your child has been invited to take place. Information from questionnaires and interviews will have names and other identifying information taken from them before using any quotes or other information in reports or other publications. Questionnaires and interview tapes will be kept in a secure place and only accessed by the research team. The only time we would tell anyone else what you or your child have told us is if we are worried out their safety or the safety of someone else.

**Did anyone else check the study is OK to do?**

The Primary Care, Community and Mental Health Research Ethics Committee has approved this study.



**What if there is a problem?**

Contact Dr Julie Bennett and she will do her best to help you. If you need to make a formal complaint you should contact Dr Helen Minnis, Psychiatrist and Senior Lecturer, DCFP, Yorkhill Hospital (0141 201 0220) or Professor Colin Espie, Section of Psychological Medicine (0141 211 3903), or Ms K Colquoun, Patient Services Officer, RHSC, 0141 201 9278.

**Do you have any questions about the study?**

You could call Julie Bennett on 07941 410 421 or email her on [j.bennett.1@research.gla.ac.uk](mailto:j.bennett.1@research.gla.ac.uk) if you would like some more information. Julie Bennett is training to be a Clinical Psychologist at the University of Glasgow.



Information Sheet for Children and  
Young People:  
An Exploration of Children's Experience of  
Indiscriminate Friendliness



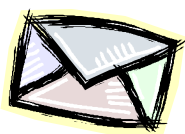
UNIVERSITY  
of  
GLASGOW

**PART 1**

Some children find it very easy to be friendly towards lots of people, even people they don't know very well. Does this sound like you? If it does we'd really like to meet you and speak to you about this if it's ok with your parents or carers. We're really interested in finding out some more about friendliness and it would be really helpful if you could help us by joining our study.

Before you decide if you want to join in it's important to understand why the research is being done and what it will involve for you. So please read this leaflet carefully. Talk about it with your family if you want to.

**What happens if I decide to join your study?**



Speak to your parents about this. If you all decide that it's ok for you to help out in this study you need to sign the consent form for children and one of your parents or carers need to sign the parent/carer consent form. Send these off in the envelope included in this invitation pack.



We will send you a questionnaire to fill out about yourself and we'll ask your parent/carer to fill out two questionnaires about you as well. We will also ask you to let us know where is the best place for us to meet up for our interview. When we look at the questionnaires you and your family send us we can let you know if we think you'd be able to help us with the study.



After you have sent the questionnaires back to us Julie might send you a time and place for you to meet you and your family. You can ask her any questions you have about the study when you meet up.



Soon after your first meeting Julie will ask you to meet her again to speak to you about friendliness. You might just talk about times when you've been really friendly with other people or she might ask you to draw pictures about friendliness. This will take about half an hour. Your conversation with Julie will be taped if that's ok with you.

Then Julie will phone the person you have been seeing at your clinic to find out a bit more about the reasons you have been going there.

And that's it!

Afterwards we will listen to the tapes of the conversations children have with us about friendliness and we'll write up a report of what people have said. Once that's finished we'll send you and your family a sheet telling you what we found out from our conversations with the children who helped us.

**Do I have to take part in this study?**

No! It is up to you. If you decide you don't want to do the research anymore, just tell your parents or carers.

**Why do you want to talk to me about friendliness?**

When children are very friendly with lots of people, even strangers, they can sometimes have problems getting on with their family and in keeping their friends. Speaking with you and other children might give us information which could help you and other children have an easier time in getting on with people.

*Thank you for reading so far!*

*If you are still interested, please look at Part 2.*

**PART 2**

Will other people know what I have said when I meet with Julie and what me and my family say in the questionnaires?

We might use some of the words you have said in our report but we will change your name so that no-one knows you said that. All of the questionnaires and tapes will be kept safe so that only the research team can look at them. The only time we would tell anyone else what you have told us is if we are worried out your safety or the safety of someone else.

**Did anyone else check the study is OK to do?**

Before any research is allowed to happen, it has to be checked by a group of people called an Ethics Committee. They make sure that the research is OK to do. Your project has been checked by the Primary Care, Community and Mental Health Research Ethics Committee.



**Do you have any questions about the study?**

Speak to your parents or guardians and they might be able to answer questions for you. OR, you could call Julie Bennett on 07941 410 421 or email her on [j.bennett.1@research.gla.ac.uk](mailto:j.bennett.1@research.gla.ac.uk). Julie is training to be a Clinical Psychologist at the University of Glasgow.

## Appendix 4.10: Guardian consent form

Patient Identification Number for this trial (for use by research team): \_\_\_\_\_



### CONSENT FORM - PARENTS VERSION



Title of  
Name

ion of Children's Experience of Indiscriminate Friendliness  
Julie Bennett

Your Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Tel.No. \_\_\_\_\_

*Please read the statements below and initial the box next to each if you agree with them.*

1. I confirm that I have read and understand the information sheet dated June 2006 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my child's participation is voluntary and that she/he is free to withdraw at any time, without giving any reason, without her/his medical care or legal rights being affected. ☐
3. I consent for my child's interview to be tape recorded and for this to be transcribed. ☐
4. I agree for you to speak to my child's clinician to gain a brief outline of their difficulties. ☐
4. I understand that information from questionnaires and the interview collected during the study, may be looked at by responsible individuals from University of Glasgow Section of Psychological Medicine, from regulatory authorities or from the NHS Trust, where it is relevant to this research. ☐
5. I agree that my child may take part in the above study. ☐
6. I consent to the use of quotes from my child's interview to be used in subsequent reports and publications once identifying factors have been removed. ☐
7. I consent to being contacted in the future to be given information about any follow-up studies. ☐

\_\_\_\_\_  
Name of Parent / Carer

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return this form to Dr Julie Bennett in the enclosed self-addressed envelope (Psychological Medicine, Division of Community Based Sciences, Academic Centre, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH).

Thank you for your help.

## Appendix 4.11: Child consent form

Patient Identification Number for this trial (for use by research team): \_\_\_\_\_



### CONSENT FORM - CHILD'S VERSION



UNIVERSITY  
of  
GLASGOW

**Title of Project:** An Exploration of Children's Experience of Indiscriminate Friendliness

**Name of Researcher:** Dr Julie Bennett

**Your Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Address** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Tel.No.** \_\_\_\_\_

Please answer yes or no for each of these questions:

Have you read (or had read to you) the information about this project?	Yes/No
Do you understand what this project is about?	Yes/No
Have you asked all the questions you want?	Yes/No
Have you had your questions answered in a way you understand?	Yes/No
Do you understand it's OK to stop taking part at any time?	Yes/No
Would you like to take part in the study?	Yes/No

If any answers are 'no' or you **don't** want to take part, **don't** sign your name!

If you do want to take part, please write your name and today's date

Your name \_\_\_\_\_

Date \_\_\_\_\_

Your parent or guardian must sign a different form for you to be able to take part in the research.  
Please return this form to Dr Julie Bennett in the enclosed self-addressed envelope  
(Psychological Medicine, Division of Community Based Sciences, Academic Centre, Gartnavel  
Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH).

Thank you for your help.

## Appendix 4.12: Interview recording consent form

Patient Identification Number for this trial (for use by research team): \_\_\_\_\_



### CONSENT FORM FOR RECORDING INTERVIEW



UNIVERSITY  
of  
GLASGOW

**Title of Project:** An Exploration of Children's Experience of Indiscriminate Friendliness

**Name of Researcher:** Dr Julie Bennett

For Child/Young Person

Please answer yes or no for each of these questions:

Are you happy to have your interview taped and for this to be written up	Yes/No
Are you happy that your interview tape will be kept in a safe place	Yes/No
Is it ok to use what you say in our reports	Yes/No

If you do want to take part, please write your name and today's date

Your name \_\_\_\_\_

Date \_\_\_\_\_

If unable to sign but gave verbal assent: researcher sign here \_\_\_\_\_

For Parent/Guardian:

Please tick the box next to each statement you agree with:

I consent for my child's interview to be tape recorded and for this to be transcribed. ☐

I understand that the tape and transcription of this will be kept in a secure location. ☐

I consent for quotations from the transcript to be used in any subsequent reports of publications once identifying information has been removed. ☐

Your parent or guardian must write their name here if they are happy for your interview to be taped

Print Name \_\_\_\_\_

Sign \_\_\_\_\_

Date \_\_\_\_\_

Thank you for your help.

Appendix 4.13: Relationship Problems Questionnaire

**Relationship Problems Questionnaire**

- Abbreviated to 4 items only

*Please tick the statement that best describes your child.*

	Exactly like my child	Like my child	A bit Like my child	Not at all like my child	For Office Use Only
Gets too physically close to strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 3
Is too cuddly with people s/he doesn't know well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 5
Often asks very personal questions even though s/he does not mean to be rude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 7
Is too friendly with strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 11
Scoring	3	2	1	0	



## *Appendix 4.14: Interview Schedule*

### **Introduction Points**

- My name, Trainee Clinical Psychologist
- Asked you to speak with me to help with some research
- Going to ask you some questions about being friendly
- Might ask some questions which sound silly, just wanting to hear from you about what it's like for you being friendly
- You're the expert on what being friendly is like for you
- No right or wrong answers, not going to get into trouble
- Confidentiality: to you or to others, otherwise what you tell me is private
- If you decide that you don't want to take part in the interview it's ok to stop
- My memory isn't too good so using the tape recorder today and I may make some notes. Is that ok?
- I might interrupt you if there's something I'd like to know more about or if we're going a bit off the track.  
Ok?

---

### **Interview questions**

How did you find out about us meeting up and the work/research I'm doing?

#### **What the study is about**

- do you know?
- It's about being really friendly with lots of people
- it's about being 'too palsy' with people
- the type of thing that might make some adults worry about you keeping safe.

Why do you think you've been asked to help out with this study?

- Do people say you're too friendly with people?
  - o What do you think about that?
  - o How does that make you feel?
- Do you think you're too friendly with people?
  - o I wonder why that happens for you...

What sort of things do you think people are talking about when they say you're too friendly?

- Any examples?
- I wonder what you were thinking when that happened?
- I wonder why that happened?
- I wonder why you did that?
- What do you think the other person was thinking?

Do you remember meeting people at \_\_\_\_\_ for the first time?

- What was it like when you met the other children there?
  - What was it like when you met the staff there?
-

*Appendix 4.15: Scenarios*

*Scenario 1*

A boy/girl called John/Sarah went to see a school play with his/her mum. His/er mum sat down and thought that John/Sarah would sit next to him/her. But John/Sarah sat with a lady s/he didn't know away from his/her mum. Why do you think s/he did that?

- Why did s/he sit with a lady s/he didn't know instead of some girls/boys who were sitting near by?

*Scenario 2*

A boy/girl called Sam went to the beach with his/her family. S/he was there with his/her younger brother and older sister. They had a picnic with them and games to play. The strange thing was that Sam didn't sit with his/her family. S/he spent the day on the beach with a family s/he didn't know along the beach from his/her own family. Why do you think s/he did that?

i – Notes and exploratory codes for section of interview script (I = interviewee, J = JB)

Notes	Section of Jody's interview script	Exploratory codes
Speaks to strangers	J. What sort of adults is it that you usually talk to then? I. <b>Old ladies that I don't know...shop keepers, people like that.</b> J. Ah, so sometimes you're friendly with the shopkeepers when you're out at the shops with your mom. Has that happened recently? I. Em, yeah. Every time we go to the shop... J. What happens? I. I chat and get along with chatting to people. <b>So how do you feel about this? About me coming here. Is it strange for you?</b> J. It's very helpful for me.	Example of talking to strangers [example rather than theme]
Taking control, asking me questions	I. <b>Yes, but why do you want to know about children being adopted?</b> J. Because I'm very interested, 'cos some kids have a bad time....	
Takes on role of interviewer – avoiding my questions?	I. Lots of kids, I'll bet lots of kids. <b>I'll bet it's boring for you just having a very easy time and you never know what it's like to have a hard time so you're like asking adopted people.</b> J. 'cos you're my expert. That's why I'm asking you. You've got it right.	Pride [this was not supported across other transcripts as a theme]
Proud of her situation. Sense of being special by having had a hard time	I. <b>Do you have any more experts?</b> J. I have one other expert and I'm looking for some more at the moment. I. <b>What expert is that? A boy or girl?</b> J. It's another girl. I. <b>What's her name?</b> J. I can't tell you her name, sorry. I. <b>How old is she?</b> J. She's a bit older than you. I. <b>What age?</b> J. She's a teenager. But I'm looking for 10 children, I need lots more children. More experts like you.	Takes control
Asking me questions	I. <b>I know some other children.</b>	Takes control
Trying to help me (helpful or being avoidant?)		Kindness/Helping

ii. Excerpt from control quote table (quotes taken from above transcript highlighted in bold).

**Emergent Theme: Taking control (within insecurity overarching theme)**

Participant number	Page	Quote
1	6	[QUESTIONS ME] I. Have you ever been?
1	6	[QUESTIONS ME] I. Do you like rides?
2	4	<b>[QUESTIONS ME]</b> <b>I. So how do you feel about this? About me coming here. Is it strange for you?</b> <b>J. It's very helpful for me.</b> <b>I. Yes, but why do you want to know about children being adopted?</b>
2	4	<b>[QUESTIONS ME]</b> <b>I. Do you have any more experts?</b> <b>J. I have one other expert and I'm looking for some more at the moment.</b> <b>I. What expert is that? A boy or girl?</b> <b>J. It's another girl.</b> <b>I. What's her name?</b> <b>J. I can't tell you her name, sorry.</b> <b>I. How old is she?</b> <b>J. she's a bit older than you.</b> <b>I. what age?</b>
2	3	[DIRECTING INTERVIEW] I. So can you move on to things like being adopted?
2	14	[SUGGESTIONS ADDITIONAL INTERVIEW] I. We're all going on holiday to A Campsite. There'll be lots of other adopted children. I'm going to ask them. And if I come see you another day....
3	7	[DIRECTS INTERVIEW ] I. Is this on? J. Yes. I. Can we stop it and see what it sounds like?
3	14	[DISTRACTS FROM INTERVIEW] I. What's all this? [points to graffiti on walls]
3	19	[ATTEMPTS TO DIRECT ME] J. I've been talking to other children. I. What did they say? J. I can't tell you. I. Oh please. J. Well, the thing is, if I tell you what they said then... I. I won't copy them. I promise. J. Yeah, I know you wouldn't copy them but it's confidential, it's private to them. Like, I won't tell other children what you've told me. I. Why? J. I won't tell other children what you've told me. I. Well, maybe you can just tell me. If you just tell me what they said I won't tell anyone else. J. I can't do that.